

Valparaiso University Cheer and Dance Clinic

Saturday, October 22, 2011 at the Athletics-Recreation Center

Kindergarten through 6th Grade

Noon - 4:00 p.m. (CT)

Performance at the VU Volleyball game immediately following (concluding at approximately 6:00 p.m.)

Meal will be served in late afternoon

\$40 (includes T-Shirt)

Pre-registration is encouraged, but participants can also register on day of clinic

Registration starts at 11:00 a.m. in the Athletics-Recreation Center

Questions? Please call Laura at 219-628-3833

Please make checks payable to Valparaiso University and send completed registration to:

Athletics-Re Attn: Laura ` 1009 Union Valparaiso, I	Yoder Street						
Name:						_ Grade:	
Parent/Gua	rdian Nar	ne:		 			-
Phone Num	ber:						
Address:							
Tee Size:	YS	YM	YL	AM	AL		

Please fill out this form completely. It is important for the provision of proper medical care. The section Marked "Physician's Comments" need only be completed if the participant has a major health problem. When older participants are seen for minor illnesses or injuries, they are encouraged to inform their parents themselves. However, with younger participants in almost every instance or with older participants with more serious problems, the physician will try to contact the parents to inform them of the problem and discuss the treatment. Occasionally, we are unable to reach parents immediately to inform them of a serious problem. The parent's signature on the medical treatment authorization allows us to go ahead with treatment in these circumstances. The Training Room staff, Porter Memorial Hospital or the Athletics Office will continue to call until contact is made with the parent or guardian. **THIS FORM MUST BE ON FILE BEFORE YOUR CHILD CAN PARTICIPATE!!!**

 NAME OF CAMP: Cheer & Dance
 CAMP DATES: 10/22/11

MEDICAL HISTORY

1. PERSONAL INFORMATIO	N (PLEASE PRINT)				
Name	Sex: Male Female				
Home Address					
Street	City	State	Zip		
Phone	Date of Birth	Age			
IN CASE OF EMERGENCY NO					
Address	NAME OF PARENT O	R NEXT OF KIN RE	LATIONSHIP		
Home Phone	Business Phone	Cell Phone			
Family Physician	Phone				
Address					
2. FAMILY HISTORY (PLEAS Do you have a family history o	,				
Diabetes Tuberculosis	Cancer Heart Disease	Kidney Disease	Migraine		
3. PERSONAL HISTORY Immunization Record (include	dates, if possible, if not ple	ase specify if shots a	are current)		
DPT MMR_	Polio				
Most Recent TETANUS BOOST	ſER:				

Allergies - Particularly to medications (please list)

Have you had any of the following: (please circle)

Asthma	Bleeding Disorder	Diabetes	Heart Condition	Kidney Disease
	any of the following you			
	d Injuries			
	ctures (please specify)			
Sur	gery			
Hos	pitalization			
List any m	edications you are curr	ently taking a	nd include directio	ns:

4. PHYSICIAN'S COMMENTS (OPTIONS)

Note to physician: Please provide a brief history of the camper's problem, any pertinent physical findings or laboratory values, and a description of therapy. Also please list any ways in which we may help to care for your patient. Thank you.

5. **INSURANCE INFORMATION** (participant **<u>MUST</u>** be covered by a health insurance policy)

Name of Company_____

Company Address_____

Group Number_____

6. MEDICAL TREATMENT AUTHORIZATION AND LIABILITY RELEASE

I, the undersigned parent or guardian, do hereby grant my permission for my daughter/son to attend the Valparaiso University Sports Camp in all activities thereof. In the event of an injury or illness during these activities, even if I cannot be directly contacted at the time, I hereby authorize Porter Memorial Hospital to provide the medical treatment deemed necessary. I hereby release Valparaiso University and Porter Memorial Hospital and their agents, employees, and representatives from any and all claims and liability arising in any way out of its exercise of this authority. I understand and agree that all bills for medical care and treatment will be forwarded to my insurance company or me, and that it will be my responsibility to see that such bills are paid. I further acknowledge, understand, and agree that in participating in this activity there is a possibility of physical injury or illness and that my daughter/son is assuming the risk of injury by his/her participation. I further authorize the program director of his/her staff, or the training room staff to administer non-prescription analgesics for minor problems such as headaches, etc.

Parent / Guardian	signature	 Date	
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