

**2017 BINGHAMTON VOLLEYBALL CAMP  
AT BINGHAMTON UNIVERSITY  
INSURANCE AND MEDICAL INFORMATION FORM**

Camper's Name \_\_\_\_\_ Age \_\_\_\_\_  
Camp(s) Attending \_\_\_\_\_  
Parent's Name \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone (        ) \_\_\_\_\_ Birth Date \_\_\_\_\_  
Parent(s) Work Phone # (        ) \_\_\_\_\_  
Family M.D. \_\_\_\_\_  
Telephone # (        ) \_\_\_\_\_  
Email: \_\_\_\_\_ T-shirt Size \_\_\_\_\_ Grade \_\_\_\_\_

**MEDICAL INFORMATION**

(Please check any of the following which apply now)

- |   |  |
|---|--|
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Nervous or Emotional                  |
| <input type="checkbox"/> Epilepsy   | <input type="checkbox"/> Contagious Disease or Recent Exposure |
| <input type="checkbox"/> Heart or lung condition                              | <input type="checkbox"/> Physical Handicap                     |
| <input type="checkbox"/> Allergies, please describe and list medicines below: | <input type="checkbox"/> Asthma                                |

Please list all other medications and what they are taken for:

Orthopedic conditions, injuries, or surgeries within past year, explain:

Please describe briefly any additional information with regard to checks noted above and any other medical information not noted above:

**INSURANCE INFORMATION**

This volleyball camp requires all campers to carry health insurance coverage. The parent/guardian's personal or injury insurance policy will be utilized as the primary insurance for the treatment of injuries and hospitalization for illness or injuries incurred during the sports camp. If you do not possess health coverage, a temporary policy must be purchased (through your insurance agent) to cover the camper for the duration of the camp.

**\*The name of your health insurance carrier and policy number must be written below in order to attend the volleyball camp.**

Name of Insurance Carrier \_\_\_\_\_  
Insurance policy # \_\_\_\_\_ Group # \_\_\_\_\_

I hereby confirm that the information given on this form is true to the best of my knowledge. I do hereby consent to allow a representative of the camp, or a qualified medical person, to act in behalf of the above named person in authorizing medical treatment, follow-up care, and/or referral to local physician or local hospital for emergency care in the event this should become necessary while attending this camp. I further acknowledge I will be responsible for any sickness, and understand that I will be required to show proof of insurance coverage for my son/daughter for injuries that may occur during camp; and that Binghamton assumes no responsibility for medical and dental expenses resulting from those injuries.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
Parent or Guardian