Cape Cod Volleyball Camps
PO Box 303
S. Harwich MA 02661
508-776-2972
capecodvolleyball@comcast.net
www.capecodvolleyball.com

Camp forms checklist

The below paperwork and forms must be completed and mailed to the camp office prior to the camper attending camp.

Please mail them to:

Cape Cod Volleyball Camp
PO Box 303
South Harwich MA 02661

_____ A report of a physical exam within the last 2 years. (Doctor's office)

_____ Immunization record (Doctor's office)

_____Authoization to Administer Medication to a camper

_____ Health history

_____ Authorization of emergency medical release

_____Waiver and release form

Thanks,
Tom Turco
Camp Director

AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER

Please fill out and return this form ONLY if your child will be taking medication at Camp.

Name of Camper: _____ Age: _____

Food/Drug Allergies: _____

Diagnosis (at parent's discretion): _____

Parent/Guardian Name: _____

Home Phone: _____ Business: _____ Cell: _____

Name of Licensed prescriber: _____

Name of Medication: _____

Dose given at camp: _____ Route of Administration: _____

Frequency: _____ Date Ordered: _____ Duration of order: _____

Quantity Received: _____ Expiration date of Medications received: _____

Special storage requirements: _____

Specific directions (e.g., on empty stomach, with water): _____

Specific precaution: _____

Possible side effects/adverse reactions: _____

Other medications (at parents' discretion): _____

Location where medication administration will occur: _____

(OVER)

AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER (2)

I hereby authorize _____ to administer to my child,
(Name of camp)
_____ the medication(s) listed on page 1, in accordance
(Name of child)
with 105 CMR 430.160.

105 CMR 430.160(A)

Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.

105 CMR 430.160(C)

Medication shall only be administered by the health supervisor* or by a licensed health care professional authorized to administer prescription medications. The health care consultant shall acknowledge in writing the list of medications administered at the camp. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.

105 CMR 430.160(D)

When no longer needed, medications shall be returned to a parent/guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

*Health Supervisor – A person who is at least 18 years of age, specially trained and certified in at least American Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.

_____ _____

Parent/Guardian Signature Date

Health History

Last Name First Name Middle

Health History

	AGE	STATE OF HEALTH	OCCUPATION	AGE OF DEATH	CAUSE OF DEATH	HAVE YOU OR ANY OF YOUR IMMEDIATE FAMILY EVER HAD ANY OF THE FOLLOWING?			
FATHER							YES	NO	Relation
MOTHER						High Blood Pressure			
BROTHERS						Diabetes			
						Kidney Stones			
						Cancer			
						Intestine/Stomach			
SISTERS						Asthma			
						Epilepsy			
						Allergies			
						Depression			

PERSONAL HISTORY- PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in space below or on a separate sheet of paper

HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO
Scarlet Fever			Insomnia			Bronchitis			FEMALES ONLY		
Measles			Frequent Anxiety			Pneumonia			Irregular Periods		
German Measles			Depression			Chest Pain			Severe Cramps		
Mumps			Nervousness			Heart Murmur			Excessive Flow		
Chicken Pox			Dizzy/Fainting			Bladder Infection			Missed Period		
Tuberculosis			Paralysis			Sinusitis			MAJOR SURGERY		
BCG			Head Injury With			Ear/Throat			Describe:		
ALLERGY TO MEDICINE			Unconsciousness			Problem					
Penicillin			Eating Disorder			Eye Trouble					
Sulfa			Weight Gain/Loss			Tumors					
Emycin			Back Problem			Gallbladder/Stones					
Aspirin			Disease of Joints			STD's					
Codeine			Dental Problems			Herpes					
Other			Asthma/Short Breath								

Cape Cod Volleyball Camps
Medical release and Emergency Contacts

This must be completed - legibly – and signed in all areas by both the camper and his or her parent or guardian. By signing this form the participating affirms having read it.

Name_____
Last First Address

_____
Birth Date Age Gender

Parent or Guardian

Name_____
Address_____
_____
Home Phone_____
Work Phone_____
Family Physician Name_____

In Emergency, Contact:

Name_____
Home Phone_____
Work Phone_____
Primary Insurance Co._____
Primary Group/Policy #_____
Does this policy cover sport related accindents?____yes ____no

Participant,_____, has my permission to participate in training, competition, events, and activities. I approve of the leaders who will be in charge of this camp. I recognize that the leaders are serving to the best of their ability. I certify that the participant has full medical insurance with the company listed above. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

Signed_____ Date_____
Relationship_____

To the Club Leaders:

If, during the course of my daughter's/son's activities in volleyball, she/he should become ill or sustain and injury, I hereby authorize you to obtain emergency medical/dental care.

Signed_____ Date_____
Parent or Guardian

I do not authorize emergence medical/dental care for my daughter/son.

Signed_____ Date_____

List of conditions physicians should be aware of:_____
_____
_____
_____

Allergies:_____
_____

AMATEUR ATHLETIC MINOR WAIVER AND RELEASE OF LIABILITY FORM

PARENTS - Please read the following, sign the form and provide the requested information.

In consideration of being allowed to participate in any way in the Cape Cod Volleyball Camps Inc., camps / sports programs , and related events and activities, the undersigned:

1. Agree that the parent(s) and/or legal guardian(s) will instruct the minor participant that prior to participating, he or she should inspect the facilities and equipment to be used, and if the participant believes anything is unsafe, he or she should immediately advise his or her coach or supervisor of such condition(s) and refuse to participate.

2. Acknowledge and fully understand that each participant will be engaging in activities that involve risk of serious injury, including permanent disability and death, and severe social and economic losses which might result not only form their own actions, play. or the condition of the premises or any equipment used. Further, that there may be other risks not known to us or not foreseeable at this time.

3. Assume all the foregoing risk and accept personal responsibility for the damaging following such injury, permanent disability or death.

4. Release, waive, discharge and covenant not to sue , Cape Cod Volleyball Camps Inc., its affiliated clubs, their respective administrators, directors, sponsors, advertisers, and if applicable, owners and leasers of premises used to conduct the event, all of which are hereinafter referred to as “releasees”, from any and all liability to each of the undersigned, his or her heirs and next of kin for any and all claims, demands, losses or damages on account of injury, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the releasees or otherwise.

I/We have read the above waiver and release, and I/We understand that I/We have given up substantial rights by accepting/submitting this form and I/We hereby do so voluntarily.

Player Name _____

Address _____ Phone _____

Parent or Guardian (Signature/Relationship) Date (mo/da/yr)

_____ _____

Parent or Guardian (Signature/Relationship) Date (mo/da/yr)