

Name of Participant (*print full legal name*) \_\_\_\_\_

Birth Date \_\_\_\_\_ Gender (circle one) Male Female

Camp(s) (Circle all attending) All Skills-Cardinal All Skills-Gold Setter Libero Team \_\_\_\_\_  
School Name

**Release and Medical Authorization**

The release and the treatment authorization must be signed by a parent or guardian if student is under 18 years old. Students who are 18 years old or will become 18 years old before the end of the camp/clinic must also sign. In order for students to participate in camp activities, we must have this form prior to the camp's start date. Otherwise, parent or guardian must be contacted prior to release to participate.

**Release of Liability, Medical and Surgical Authorization**

In consideration of the Cyclone Volleyball Camps of Iowa State University granting the student permission to participate in Cyclone Volleyball Camps, I hereby assume all risks of his or her personal injury (including death) that may result from any Cyclone Volleyball Camp activity. As guardian I do hereby release the State of Iowa, Iowa State Board of Regents, Iowa State University, Cyclone Volleyball Camps and their officers, employees, agents, all instructors, and all participants in said Cyclone Volleyball Camps from all liability, including claims and suits at law or in equity, for injury, fatal, or otherwise which may result from the student taking part in Cyclone Volleyball Camps activities.

In addition, I hereby authorize and give my consent to the health authorities of Iowa State University or any licensed health professional to perform upon or administer any reasonable, necessary surgical or medical treatment. I also give permission to administer whatever anesthetic may be necessary or advisable during the medical or surgical procedures. This authorization is intended to cover emergency treatment, immunizations, injections, and minor operations and procedures. In the case of psychiatric and/or psychological treatment, parent authorization for treatment beyond that responsive to the emergency will be requested. I agree to assume all costs related to such treatment. I authorize my insurance company to pay benefits to Iowa State University Health Service or other hospitals and clinics.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

Also, I authorize the disclosure of medical information to my insurance company for purpose of claim. I understand that I will be responsible for any medical or other charges in connection with student's attendance at this camp.  
(Each camper must provide his/her own medical insurance.)

**Insurance Information (please print)**

Name \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Policy No. \_\_\_\_\_

Policy Holder \_\_\_\_\_

Does your insurance carrier require prior approval? Yes No

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**Medical Authorization Required only if NO current (within one year of camp date) physical is available.**

This is to certify that this individual was examined by me on \_\_\_\_\_ (valid if within one year of camp) and that I found this individual to be physically able to participate in vigorous physical and competitive athletic sports.  
*School physical form acceptable if valid within one year of the starting date of camp.*

Date of physical exam \_\_\_\_\_ Allergies/Drug sensitivities \_\_\_\_\_

Other medical problems/current medications \_\_\_\_\_

An identification band or card carried to alert others to the allergy(ies), medical conditions or medication use? Yes / No

Signed (Physician) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Office Phone \_\_\_\_\_