

# **Philip "Flip" Piontek Volleyball Camps Medical Treatment Consent Form**

Age \_\_\_\_\_

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(Print Full Name of Minor)

will be attending the Flip Piontek Volleyball Camp on the campus of The University of Central Missouri on \_\_\_\_\_. I or assigned chaperones give permission to the Flip Piontek Volleyball Camp to act on my behalf for the above minor in granting permission for evaluation/treatment of minor medical problems.

**I understand that should a major medical problem arise, I will be notified by telephone. In the event that I cannot be reached, I hereby give my consent to such medical treatment deemed necessary, including x-ray examinations and anesthesia to be rendered to said minor by a licensed physician or licensed physicians.**

I hereby certify I have read and fully understand this authorization.

\_\_\_\_\_/\_\_\_\_\_  
(Signature of Parent/Guardian) (Date)

Telephone: \_\_\_\_\_/\_\_\_\_\_  
(Home) (Cell or Work)

Address: \_\_\_\_\_  
(Street) (City, State, Zip)

Please provide the following information concerning your camper:

Allergic Reactions to: \_\_\_\_\_

Medications Presently Being Taken: \_\_\_\_\_

Any past illnesses or other information that would be useful in the event medical treatment is needed:

\_\_\_\_\_

Payment will be made by: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

\_\_\_\_\_  
(Address of Insurance Company) (City, State, Zip)