

SoccerShelburne

Program Health & Release Form

****BRING THIS FORM WITH YOU TO CHECK-IN****

Contact Information

Participant's Name: _____

DOB: _____ Age: _____ Weight: _____ Height: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Parent/Guardian Name: _____ Phone (h): _____ Phone (c): _____

Parent/Guardian 2 Name: _____ Phone (h): _____ Phone (c): _____

If Parents/Guardians cannot be reached, contact:

Emergency Contact Name: _____ Phone: _____

Health and General History

If the participant should be restricted from any activity please note:

If the participant will be taking any medication while involved in the program, please indicate the name of the drug(s) and dosage: _____

Please indicate any medical condition or medical history that may require special attention:

I hereby certify that that the named participant is in good health, and fully able to participate in all activities at the Panther Soccer Academy. I know of no restrictions, physical impairments, or any other factors, which in any manner limit her participation in such a program.

Parent Name (Printed): _____

Parent Signature: _____ Date: _____

Please circle those illnesses or conditions that the camper has had:

German Measles Measles Mumps Asthma Chicken Pox Pneumonia Diabetes High Blood Pressure

Immunizations		Allergies		Drug Reactions	
Type	Date	Type	Date	Type	Date
Tetanus		Hay Fever		Sulpha	
Polio Vaccine		Asthma		Penicillin	
Tuberculosis Test		Eczema		Antibiotics (Type)	
Measles		Insect Stings		Aspirin	
Rubella		Nuts		Other:	
Mumps		Other:		Other:	

Physician's Name: _____ Phone: _____

Health Insurance Information

Carrier Name: _____ Policy Number: _____

Policy Holder Name: _____ Policy Holder DOB: _____

I, the parent (guardian) of _____, give permission for the named clinic participant to receive emergency medical or surgical treatment and hospitalization if necessary. I understand that every attempt will be made to contact me, or the emergency contact named above, before taking this action. I will be financially responsible for any medical attention needed during the clinic or resulting from an injury received during the clinic. My medical insurance shall be the insurance coverage for any medical treatment. I further agree that my child can receive over-the-counter remedies (Tylenol, Sudafed, etc).

____ Please initial this line if you DO NOT want your child to receive over-the-counter medications

The registrant recognizes that the games of soccer is a physical activity during which injuries may occur. I certify that my child is in good physical health, and has my permission to participate in SoccerShelburne programs. I hereby release and indemnify SoccerShelburne and its affiliated organizations, sponsors, directors, employees, and volunteers from any liability claim on behalf of the registrant.

The undersigned expressly agrees that the release and assumption of risks agreement is intended to be as broad and inclusive as is permitted by law and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

Signed: _____ Date: _____

