

Play with the Pro's Soccer Camp

Please type or print in ink and fill in all sections.

Attendee Name	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Street Address		
City, State, Zip		
Parent/Guardian Name		
Home Phone No.	Emergency Phone No.	
Date of Birth/Age	T-Shirt Size	
School/Club Team Name		
Position	Skill Level	(ie: Varsity/JV, etc)
Medical Insurance Company		
Medical Insurance Policy Number		

I verify that my child has medical insurance and is physically able to participate in **Play with the Pro's Soccer Camp**. I agree to allow my child to be treated by a licensed physician if necessary. I understand there will be no refund of the deposit unless the camper is declared unable to participate by a physician.

Parent Signature

Date

Check payable to **Play with the Pro's Soccer Camp** to cover the full registration fee and/ or the \$49 non-refundable deposit.

Mail application to:

Play with the Pro's Soccer Camp
2 Sharon Drive
Lansing, NY 14882
Phone: (607) 592-4972
Email: hornibrookd@cortland.edu

Authorization For Medical Treatment of Minors

Camper Name _____ Gender M F Date of Birth _____
 Address, City & State _____ Home Phone _____
 Parent/Guardian Name _____ Work Phone _____

Insurance Company _____ Policy/ID No. _____
 Name of Policy Holder _____ Group No. _____

Note: A copy of your insurance card must be returned with this form.

Please list two additional contacts in case of emergency (other than parents)

Name, Phone, Relationship _____

Name, Phone, Relationship _____

Medical Authorization

*I/We, being the parent(s) or legal guardian(s) of the above named minor, do hereby appoint the staff of the **Play with the Pro's Soccer Camp**, to act in my/our behalf in authorizing emergency medical, dental, surgical care and hospitalization for the above-named minor during the following period of **Play with the Pro's Soccer Camp**:*

Signature of Parent/Guardian

Date

Signature of Witness

Date

Participant Medical Information

Immunization Information:

Please provide a copy of your child's current school immunization records or complete the section below.

DPT Series	Date 1	Date 2	Date 3	Booster
Polio OPV	Date	Booster	Tetanus Booster	Date
Measles Vaccine (live)	Date	Mumps Vaccine (live)	Date	
TB Test	Date	Result	German Measles	Date

Medical Information:

Date of last physical examination _____

Name of Physician _____ Telephone No. _____

Family History: (Please list all family diseases, i.e. Diabetes, Tuberculosis, Epilepsy)

Personal History (Check the following diseases or conditions the child has had)

Allergy Injections		Anemia		Bronchitis		Epilepsy
Chicken Pox		Chronic intestinal problem		Diabetes		Hives
Congenital or heart problem		Diphtheria		Eczema		Hepatitis
Emotional Disorder		Frequent Colds		Sore Throats		Hay Fever
Infectious jaundice		Kidney Disease		Malaria		Malignancy
Measles		Rubella (English/Red)		Rubella		Mumps
Mononucleosis		Orthopedic Problems		Otitis media		Tonsillitis
Hearing Impairment		Poliomyelitis		Pneumonia		Sinusitis
Psychiatric Disease		Rheumatic Fever		Scarlet Fever		TB Contact
Rheumatoid arthritis		Seizure Disorder		Speech Defect		Tuberculosis
Whooping Cough						None of the above

Severe injuries/operations and dates _____

Medical problems, drug or food allergies _____

Medications being taken at present _____

I certify that the medical information included on this form is correct.

Signature: _____ Date: _____

SELF-MEDICATION RELEASE AUTHORIZATION

(This section must be completed for students who request to carry their own medications during the camp)

_____ has been instructed in the proper use of the following
(Child's Name)

medication procedures: _____

_____ and _____
(physician's signature) *(parent's signature)*

request that _____ be permitted to carry the medication on his/her
(child's name)

person, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

Dated: _____

Parent and Prescriber's Authorization for Administration at Camp

Authorization for Administration of Medication

A. To be completed by parent or guardian:

I request that my child _____ age _____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the camp Medical Director will administer the medication or an adult will supervise my child taking his/her own medication.

Signature of parent/guardian _____ Date _____

Address _____ Telephone Home _____ Work _____

B. To be completed by licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Patient name _____ Date of Birth _____

Diagnosis _____

Name of Medication _____

Prescribed dosage, frequency and route of administration _____

Time to be taken during camp hours _____

Duration of treatment _____

Possible side effects and adverse reactions (if any) _____

Other recommendations _____

Name of Licensed Prescriber and Title (please print) _____

Prescriber's signature _____ Date _____

Address and telephone _____

All sports school forms, and any balance due, must be received in our office *two weeks* prior to the beginning of camp. Please mail forms to:

: Play with the Pro's Soccer Camp
2 Sharon Drive
Lansing, NY 14882

Should you have any questions please call (607) 592-4972