



# FC PUMA SUMMER CAMP 2009 Health/Release Form

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Camper's Name (please print) \_\_\_\_\_ Gender (M/F) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please check session(s) attending:	
<input type="checkbox"/> <b>Session I</b> July 6 - 10 9am - 3pm Ages 7 - 14	<input type="checkbox"/> <b>Session II</b> July 13 - 17 9am - 3pm Ages 7 - 14
<input type="checkbox"/> <b>Session III</b> August 2 - 7 9am - 3pm Ages 7 - 14	<input type="checkbox"/> <b>Session IV</b> August 10 - 14 9am - 3pm Ages 7 - 14
<input type="checkbox"/> <b>Session V</b> August 9 - 13 5pm - 8pm High School Pre-Season	

## In Case of Emergency

Name of Father \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Home Address \_\_\_\_\_

Name of Mother \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Home Address \_\_\_\_\_

Other Emergency Contact (print name and number) \_\_\_\_\_

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

Name of Policyholder \_\_\_\_\_ Policy # \_\_\_\_\_

## Release Form

In the event of an emergency requiring medical attention, I hereby grant permission to the athletic training staff, a physician, or to hospital personnel designated by the camp staff to attend to:

Name of Camper \_\_\_\_\_

I expect every effort will be made to contact me in order to receive my specific authorization prior to any hospitalization.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Emergency Phone \_\_\_\_\_

Pediatrician/Physician \_\_\_\_\_ Phone \_\_\_\_\_

## Medical Clearance

(Please have physician fill out.)

\_\_\_\_\_

Camper's Name

\_\_\_\_\_

Date of Birth

\_\_\_\_\_ has been examined and his/her health history and immunization records  
Name of Camper (please print)  
have been reviewed. There are no apparent physical or emotional conditions that contraindicate  
participation in soccer camp activities. He/she is free of any communicable diseases at this time.

Date of most recent Tetanus Toxoid Immunization \_\_\_\_\_

Allergies (e.g., food, drugs, asthma, others) \_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, please explain \_\_\_\_\_

Current medications \_\_\_\_\_ No \_\_\_\_\_ Yes

If you have any specific medical instructions for our staff, please indicate: \_\_\_\_\_

\_\_\_\_\_

Describe any current injuries (i.e., ankle, knee, wrist, shoulder): \_\_\_\_\_

\_\_\_\_\_

Health Care Provider Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_