



FC PUMA SOCCER ACADEMY

Youth Summer Camps

2011 Health/Release Form

www.fcumasocceracademy.com

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

Date of Birth _____ Age _____

Home Address _____

City _____ State _____ Zip _____

- Please check session(s) attending:
- Session I June 27 - July 1 Ages 7 -14 Boys & Girls
Hudson Portugese Club 9AM - 3PM
 - Session II July 11 - 15
Hudson Portugese Club
 - Session III August 1 - 5
Hudson Portugese Club
 - Session IV August 8 - 12
Hudson Portugese Club
 - Session V August 15-19
Stow Community Park

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 _____