

BERGEN'S BEST SOCCER CAMP

Date of Camp Week

Name _____ School _____

Address _____ Phone _____
(Home)

_____ Phone _____
(Work)

Family Physician _____ Phone _____

MEDICAL HISTORY

(TO BE COMPLETED BY PARENT/GUARDIAN)

HAS YOUR CHILD EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

	<u>Yes</u>	<u>No</u>	<u>Medication</u>
Asthma
Allergies
Respiratory Illness
Fainting/ Seizures
Head Injury
Eye Injury/Impairment
High Blood Pressure
Heart Problems/ Murmur
Diabetes
Hernia
Insect/ Bee Sting
Orthopedic Injury Date
Surgery Date
Physical/Mental Limitation (Describe on back)
Other Illness/ Injury?

Date of Last Tetanus

PARENT'S / GUARDIAN STATEMENT

I/We hereby grant permission for my son/daughter to participate in the **BBSC**. I/We acknowledge the possibility of injuries occurring from participation in camp activities. I/We agree to waive claims for damages and/or bills incurred because of accidents or injuries to my son/daughter as a result of his/her participation in camp activities. In the event of an emergency where my child needs further care that is not provided by Bergen's Best Soccer Camp, I give permission to transport via ambulance or other transport group to The Valley Hospital.

I have read the above and agree.

Parent's/ Guardian's signature _____