BERGEN'S BEST SOCCER CAMP

Date of Camp Week . . . . . .

Name _____

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?

	Yes	No	Medication	
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	….	….	….	
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.

I have read the above and agree.

Parent's/ Guardian's signature _____