Contact Information

Middlebury College Field Hockey

Field Hockey Camps Health & Release Form

\*\*BRING THIS FORM WITH YOU TO CHECK-IN\*\*

Participant’s Name:

DOB: Age: Weight: Height:

Address: City: State: Zip:

Home Phone: Cell Phone:

Email:

Parent/Guardian Name: \_ Phone (h): Phone (c):

Parent/Guardian 2 Name: Phone (h): Phone (c):

If Parents/Guardians cannot be reached, contact:

Emergency Contact Name: Phone:

Health and General History

If the participant should be restricted from any activity please note:

If the participant will be taking any medication while involved in the program, please indicate the name of the drug(s) and dosage:

Please indicate any medical condition or medical history that may require special attention:

I hereby certify that that the named participant is in good health, and fully able to participate in all activities at the Panther Soccer Academy. I know of no restrictions, physical impairments, or any other factors, which in any manner limit her participation in such a program.

Parent/Guardian Name (Printed):

Parent/Guardian Signature: Date:

Please circle those illnesses or conditions that the camper has had:

German Measles Measles Mumps Asthma Chicken Pox Pneumonia Diabetes CoVID-19 High Blood Pressure

|  |  |  |
| --- | --- | --- |
| Immunizations | Allergies | Drug Reactions |
| Type | Date | Type | Date | Type | Date |
| Tetanus |  | Hay Fever |  | Sulpha |  |
| Polio Vaccine |  | Asthma |  | Penicillin |  |
| Tuberculosis Test |  | Eczema |  | Antibiotics (Type) |  |
| Measles |  | Insect Stings |  | Aspirin |  |
| Rubella |  | Nuts |  | Other: |  |
| Mumps |  | Other: |  | Other: |  |

Has the camper been vaccinated against CoVID-19? Yes/No (circle one).

If Yes, please indicate vaccine dates: Dose 1: Dose 2: (circle one: pfizer/moderna/J&J)

Physician’s Name: Phone:

Health Insurance Information

Carrier Name: Policy Number:

Policy Holder Name: Policy Holder DOB:

I, the parent (guardian) of , give permission for the named clinic participant to receive emergency medical or surgical treatment and hospitalization if necessary. I understand that every attempt will be made to contact me, or the emergency contact named above, before taking this action. I will be financially responsible for any medical attention needed during the clinic or resulting from an injury received during the clinic. My medical insurance shall be the insurance coverage for any medical treatment. I further agree that my child can receive over-the-counter remedies (Tylenol, Sudafed, etc).

 Please initial this line if you DO NOT want your child to receive over-the-counter medications

I HAVE READ THE REGISTRATION PACKET AND FULLY UNDERSTAND OUR OBLIGATIONS STATED THEREIN AND ALSO THE RIGHTS OF MIDDLEBURY COLLEGE, AND HEREBY AGREE TO ACT IN ACCORDANCE. The undersigned expressly

agrees that the release and assumption of risks agreement is intended to be as broad and inclusive as is permitted by law and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

Signed: Date: