_____ Camper _____ Staff

JUST FOR KICKS, LLC – WAIVER AND EMERGENCY INFO

This form must be completed each year even if a returning camper! Thank you!

EMERGENCY MEDICAL FORM AND RELEASE

Name: _____ Date of Birth: _____
Address:_____ Town: _____ State: ____ Zip:_____
Home Phone: _____ Parent Cell:_____

In case of emergency, attempt to contact the following people **:**

	Name	Relationship	Phone Number(s)
1.	_____	_____	_____
2.	_____	_____	_____

Doctor: _____ Phone: _____
Hospital Preference: _____

Please list ***ALL*** medical conditions which may ***in any way*** effect or limit the athlete's ability to participate, or which responding medical personnel may need to know in the event of an emergency. (i.e. – asthma or other respiratory conditions, history of seizures, dizziness, fainting, heart problems, all previous injuries or surgeries, etc.) _____
_____
_____

Please list ***ALL*** medications being taken by the athlete, and the medical condition for which she/he takes them:
_____
_____

Please list ***ALL*** allergies, including medicines, foods, insects and other environmental causes, and the symptoms they cause: _____
_____

Please list ***ALL*** medications which will be provided for use at camp (i.e.- inhaler, epi-pen, etc.): _____
_____

**** Please bring clear written instructions for the use of any medications, and give them to our First Aid Director on the first day of camp.**

Primary Insurance Carrier: _____Policy Number: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT AND USE OF PHOTOS/VIDEO

I give my permission for **x**_____ to participate in The Just for Kicks Soccer camp at St. Thomas Seminary. I realize that athletic activities, such as those taking place at Just for Kicks involve the potential for injury which is inherent in all sports. I acknowledge that even with the best coaching and supervision, proper use of equipment, and strict observance of rules, injuries are still a possibility. On rare occasions, such injuries can be so severe as to result in total disability, paralysis, or even death. I also give permission for use of my child's image at any/all Just for Kicks events in photographs or video to be used for future promotional/marketing materials for Just for Kicks, LLC. I hereby authorize you to take whatever action you deem necessary to provide for the health and welfare of my child, **x** _____**,** in case of an emergency.

x _____	**x** _____	**x** _____
Parent or Guardian Name (**Please Print**)	Parent's or Guardian's Signature	Date

Please return this form and a copy of a (school or camp) Physical from within the Past Three (3) Years that includes all immunizations to:

Just for Kicks, LLC, 27 Linbrook Road, West Hartford, CT 06107

or scan to: soccerjustforkicks@gmail.com

_____ Camper _____ Staff

YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF

Physical Exams Are Valid For 3 Years

From Date of Last Examination

☐Camper
☐Staff

Please Return Completed Form to the Camp

Name _____Date of Birth _____Phone_____

Guardian_____Address_____

Emergency Contact_____Telephone_____

☐ Week 1camper ☐ Week 2 camper ☐ Both week camper

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam ____/____/____

_____ May participate in all camp activities
_____ May participate except for: _____
_____
Medical information pertinent to routine care and emergencies:_____
_____
Is this individual taking prescription or over the counter medication(s)? ☐YES ☐ NO If yes, indicate names of medication(s):_____

Does the individual have allergies?	☐YES	☐NO	Explain: _____
Is the individual on a special diet?	☐YES	☐NO	Explain: _____
Does the individual have special needs?	☐YES	☐NO	Explain: _____

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

Measles	☐YES	☐NO	Hepatitis B	☐YES	☐NO
Mumps	☐YES	☐NO	Diphtheria	☐YES	☐NO
Rubella	☐YES	☐NO	Pertussis	☐YES	☐NO
Chickenpox	☐YES	☐NO	Pneumococcal conjugate	☐YES	☐NO
Tetanus	☐YES	☐NO	Polio	☐YES	☐NO

Comments: _____
_____
_____

Print name of medical care provider: _____
Medical care provider's address: _____
Medical care provider's: City/Town _____ST _____Zip Code_____

_____
Signature of Physician, PA, APRN or RN

_____
Date Form Signed

_____
Telephone Number