



COMMONWEALTH Soccer Programs



PLAYER/EMERGENCY CONTACT INFORMATION

Player's Name: _____ Date of Birth: ____ / ____ / ____

Guardian #1: _____ Day #: _____ Cell #: _____

Guardian #2 _____ Day #: _____ Cell #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Home Phone: _____

MEDICAL INFORMATION (All campers MUST have insurance coverage under their parents/guardian's policy in order to participate)

Medical Company: _____ Policy #: _____ Phone: _____

Known Allergies/Conditions: _____

Physicians Name: _____ Physicians Phone #: _____

Do you give permission for your player to receive over-the-counter pain medication? _____

If so, indicate appropriate brands (ex. Aspirin, Tylenol, Ibuprofen, etc) _____

IMMUNIZATIONS: Please furnish a record of immunizations for diphtheria, tetanus, pertussis, poliomyelitis, measles (rubella), rubella (German measles), and mumps. If a camper is exempt from immunizations on medical or religious grounds, please provide a signed statement from a registered physician or a copy of State Department of Health and Mental Hygiene Immunization Certificate.

CONSENT FOR MEDICAL TREATMENT/LIABILITY RELEASE: Soccer is at times physical, contact sport. As a parent or guardian of a player enrolled in Commonwealth Soccer Programs residential camp, I hereby approve of my Childs participation. My child is in excellent health and capable of strenuous physical activity. My child is currently covered by medical insurance and I understand that I am responsible for any fees due to injuries resulting from and in connection with camp activities. I will release and hold harmless the Commonwealth Soccer Programs, its directors and staff.

In the event that medical attention is required, I understand that every reasonable attempt will be made to contact me. However, in the event of an emergency and I cannot be reached, I give permission for any care determined necessary by Commonwealth Soccer Programs.

I also give permission for Commonwealth Soccer Programs to use my player's picture or likeness in promotion or CSP camps or printed brochures.

Signature of Parent Guardian Date

Print Name Relationship to player

(Please sign and return to the address below)



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Prescription Medicine Dispensing Authorization

I hereby certify that my child is currently taking medication prescribed by a physician while attending camp. I understand the medication may not be kept by my child but will safely be held by the Camp Director/Trainer until needed.

Child's Name: _____

Room #: _____

	1 st Medication	2 nd Medication	3 rd Medication
Name of Medication:	_____	_____	_____
Date Prescribed:	_____	_____	_____
Doctor:	_____	_____	_____
Doctor's Phone:	_____	_____	_____
Dosage:	_____	_____	_____
Hours to be taken:	_____	_____	_____

Other Instructions: _____

I hereby give my permission for the above medication to be administered to my child by a Commonwealth Soccer Program Trainer/Director in accordance with the instructions given.

Signature Date

Print Name Relationship to player