P.O. Box 866
Franklin Lakes, NJ
07417 (800) GOALS-33
www.goalscamp.com

DIRECTORS
Sarah Francini
J.P. Francini

CAMP MEDICAL AND RELEASE INFORMATION

CAMPER NAME____ **AGE**________ **BIRTHDATE**______________

ADDRESS____ **CITY**_______________________________

STATE________________ **ZIP**____________

HOME NUMBER__________________________________ **CELL NUMBER**____________________________________

EMERGENCY CONTACT___________________________ **CONTACT PHONE NUMBER**___________________________

Please list any exceptions, comments, special problems, allergies, etc.

____

____

Date of most recent physical examination __________________________________

IMMUNIZATION DATES __________ Diphtheria __________ Measles __________ Mumps

__________ Poliomyelitis __________ Rubella __________Tetanus

Most recent orthopedic injuries (if any, please explain)____

RELEASE AND DISCLAIMER
Please ***initialize*** on the appropriate line below.

_______ I authorize use of player photos on the camps website or in newspapers provided my child's name is not associated with said photo.

_______ I recognize the possibility of physical injury associated with the game of soccer.

_______ In consideration for GOALs Camp Inc., I hereby release, discharge, and otherwise indemnify GOALS, its coaches, and the owners of the fields and facilities against any claims as a result of my child's participation which I hereby authorize.

I have read and completed the above medical and release information form. I give my daughter permission to participate in all camp activities, except as noted.

______________________________ ______________________ ______________________
Parent/Guardian Signature *Date Completed* *Camp Session*

PLEASE TURN OVER

PRESCRIPTION MEDICATION APPROVAL AND INSTRUCTIONS

(PLEASE COMPLETE ONLY IF CAMPER REQUIRES MEDICATION DISTRIBUTION WHILE ATTENDING CAMP!)

CAMPER NAME____

AGE__________ HEIGHT____________ WEIGHT____________

NAME OF MEDICATION(S)____

REASON FOR MEDICATION____

____

MEDICINE DOSAGE: AMOUNT____________ FREQUENCY________________

SPECIAL INSTRUCTIONS____

____

SIDE AFFECTS (IF ANY)____

____

DOCTOR ____________________________ PHONE NUMBER______________________

________________________ IS UNDER MY CARE AND IS ABLE TO SELF-ADMINISTER THE ABOVE PRESCRIPTION MEDICATION.

______________________________ ______________________________

PARENT/GUARDIAN SIGNATURE *DOCTOR'S SIGNATURE*

______________________________ ______________________________

DATE *DATE*