JUMBO SOCCER CLINICS, LLC 2024 MEDICAL HISTORY AND RELEASE FORM

*You will not be admitted to camp without this form

Contact Information:

Participant's Name:_____ Age: _____

Address:_____

City:_____ State:_____ Zip:_____

Emergency Contact Name 1:_____ Relationship: _____Phone:_____

Emergency Contact Name 2:_____ Relationship: _____ Phone:_____

Health History:

If the camper should be restricted from any activity, please note:_____

_____

If the camper will be taking medication during camp, please indicate name of drug and dosage:_____

_____

Please identify any medical condition or history that would require special attention:

_____

Has the camper or any immediate family member tested positive for COVID 19 in the last 30 days? (Circe): YES / NO

Has the camper or any immediate family member had a fever, loss of smell or taste or any other symptoms of potential exposure to COVID 19? (Circle): YES / NO

The camper has been examined by a physician within the last 12 months and is cleared to participate without restriction: YES / NO

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

Parent Name (Printed): _____

Parent Signature: _____ Date: _____

Has the camper had any of the following? (Circle all that apply): *Asthma, Chicken Pox, Diabetes, German Measles,*

High Blood Pressure, Measles, Mumps, Pneumonia, Fainting, Heart conditions, Head Injury

Are the camper's immunizations up to date? (Circle): YES / NO

Allergies: (Circle): YES / NO If yes, please explain:

_____

Drug Reactions: (Circle): YES / NO If yes, please explain:

_____

Physician's Name_____ Phone Number: _____

HEALTH INSURANCE INFORMATION:

Carrier Name:_____ Policy Number:_____

Policy Holder Name: _____ Policy Holder Date of Birth_____

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

Signed: _____ Date: _____