Middlebury College Soccer

Panther Soccer Academy Health & Release Form

BRING THIS FORM WITH YOU TO CHECK-IN

Contact Information

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 Name (Printed): ____

Parent 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:__________________

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: __________________________