# TOD SILEGY SOCCER CAMP CHESTERFIELD

## 535 Old Chesterfield Rd. (Chesterfield Elementary), Chesterfield NH, 03608

## July 15-19, 2019

### Registration and Health Form

Please enroll me in the:

| | | | |
|---|---|---|---|
| ❑ Full day regular program | (ages 6-15) | $200.00 | (9:00-3:00) |
| ❑ ½ day beginner program | (ages 6-8) | $125.00 | (9:00-11:30) |

Last Name ______________________ First Name ______________________ Age __________ Sex ❑ M ❑ F

Street Address ______________________ City ______________________ State & Zip ______________________

Height: _________ Weight: _________ Grade entering: _________

Desired position: ❑ Defender ❑ Midfielder ❑ Forward ❑ Goalkeeper

Playing experience: ❑ Town League ❑ Junior High ❑ Junior Varsity ❑ Varsity

How did you learn about us? ______________________________________________

Father/Guardian ________________________________________ Tel #_______________ Cell #_______________

E-mail _______________________________________________________

Mother/Guardian ________________________________________ Tel #_______________ Cell #_______________

E-mail _______________________________________________________

List two emergency contacts if neither of your parents/guardians can be reached:

1: ______________________________________________ Home # _____________ Work # ______________ Cell #_______________

2: ______________________________________________ Home # _____________ Work # ______________ Cell #_______________

***The above-named participant has my permission to participate in the camp program above. In case of emergency, I understand every attempt will be made to contact the person(s) above. If contact is unsuccessful, I give my permission to the attending physician to render medical treatment to the participant, including (if necessary) hospitalization. Any expense arising from injury or illness is the responsibility of the person signing below.***

Signature: ____________________________________________________________ Date: __________________________

A non-refundable deposit of $50, made out to "Tod Silegy," must accompany this application. Please call Coach Silegy (603) 352-4434 with any additional questions you may have.

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**Mail to:** Tod SIlegy, 14 Nelson Street, Keene NH 03431

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## Sports Camp Medical Form

***All medical information will be kept strictly confidential between the medical staff and camp director. Only information necessary for the proper care of any camper will be discussed with other staff members employed at the camp.***

______________________ ______________________ __________ Sex ❑ M ❑ F

Last Name First Name Age

Known medical conditions or concerns (chronic conditions, illnesses, injuries):

____________________________________________________________

____________________________________________________________

Current Medications (name, dosage, how often): ______________________________

____________________________________________________________

Allergies (to what, what is reaction and treatment?): ______________________________

____________________________________________________________

*Insurance company: ______________________ Policy #:______________________

*Policy Holder: ______________________ Group #:______________________

***Application cannot be processed without proper insurance information***

Camper's Primary Care Physician: ______________________ Tel # ______________________

### Permission to Dispense Over-the-Counter Medications

*The camp director needs permission to dispense over-the-counter medications containing active ingredients such as ibuprofen, acetominophen, etc. for general aches and pains. The camp director will not give any medications for which parents/guardians have not given explicit permission.*

Please check any over-the-counter medications that your son/daughter may receive:

❑ ibuprofen tablets (i.e. Advil 200 mg; 1 or 2)
❑ acetaminophen (i.e. Tylenol, regular or extra strength, 1 or 2)

Signature: ______________________ Date: ______________________

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