

# TOD SILEGY SOCCER CAMP WALPOLE

8 BEMIS LANE (WALPOLE ELEMENTARY SCHOOL) WALPOLE, NH 03608

## July 22 - 26, 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)

\_\_\_\_\_ Sex  M  F  
Last Name First Name Age  
\_\_\_\_\_  
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 xxx? \_\_\_\_\_

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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NH 03608

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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, acetaminophen, 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: \_\_\_\_\_