ROCKFORD RECREATION

SUMMER SOCCER CAMP-2016

DEADLINE FOR SIGN UP IS APRIL 29

Please complete this form to register your child for the Rockford Recreation Association summer soccer camp. Children who have completed any grade PreK-6 are eligible. Children who have completed one year of soccer and have completed any grade 3-6 are eligible for the intermediate soccer camp. Children in PreK-6 who are new to the program must register for the beginner's camp.

Beginners Camp – June 1-3 @ 8:30 am – 10:30 am @ Shane's Park

Includes: Basic foot skills	Dribbling	Passing	Throw Ins
Trapping	Shooting	Goaltending	Headers

Intermediate Camp – June 1-3 @ 10:30 am – 12:30 pm @ Shane's Park

Includes: Foot Skills	Dribble Turns & Moves	Goal tending
Passing & Moving	Shooting	Headers
Ball Skills	Throw Ins	

**Please bring water bottle, shinguards, tennis shoes or cleats (no metal cleats)

Registration fee is $25.00 and due at the time of registration. Players will receive a t-shirt as part of their registration fee. Late registrations **will not** receive a shirt.

PLAYER'S NAME_____ Grade Completed ('15-'16) _____

HOME PHONE_____CELL PHONE_____ TEXT Y / N

EMERGENCY PHONE_____

EMAIL ADDRESS (if checked regularly)_____

STREET ADDRESS_____

CITY, STATE, ZIP_____

T-SHIRT SIZE: YOUTH: S M L ADULT: S M L

I, the parent/guardian of the above named athlete, give my permission for his/her participation in any and all program activities. I assume all risks and hazards incidental to such participation including transportation to and from the activities and do hereby waive, release, absolve, indemnify, and agree to hold harmless the local organizers, sponsors, participants, coaches, and persons transporting my child to or from and/or claims arising out of injury to my child whether the result of negligence or for any cause.

_____

Signature of Parent/Guardian Date

ROCKFORD RECREATION ASSOCIATION
Emergency Medical Form

Name_____
(First) (Middle) (Last)

Address: _____

City, State, Zip_____

Date of Birth _____ _____ _____ Male _____ Female_____
Month Day Year

Child Lives with: _____ Both Parents _____ Mother only _____ Father only
_____ Guardian _____ Mother/Step Father _____ Father/Step Mother

Mother's Information	Father's Information
Name:_____	Name: _____
Address: _____	Address: _____
City, State, Zip _____	City, State, Zip _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Employer: _____	Employer: _____
Employer Phone #: _____	Employer Phone #: _____
Step Mother's Name: _____	Phone:_____
Step Father's Name: _____	Phone: _____
Guardian's Name: _____	Phone: _____

Is there a court custody order pertaining to this athlete? _____
If so, who has legal custody? _____

[Please note that a copy of the custody papers is required.]

In order for us to plan for a safe and healthy ball season for your child, please check any of the following that currently apply to this athlete.

____Asthma
____Epilepsy or Seizures
____Heart Condition
____Shunt
____Wears Prostheses
____Wears Corrective Lenses
____Medication taken on a regular basis
____Other Health Conditions (See Area Below)
____Bleeding Disorder
____Diabetes
____Life threatening allergies (anaphylaxis)
____Wears a hearing aid
____Has a cast, brace, or other supportive or assistive device

The space below is provided for you to list any additional information concerning your child's health or medical Conditions of which we should be made aware of:

EMERGENCY MEDICAL AUTHORIZTION

(Part I or II must be completed)

Part I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Physician _____ Phone: _____

Dentist _____ Phone: _____

Medical Specialist _____ Phone: _____

Local Hospital _____ Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent to (1) the administration of any treatment deemed necessary by the above named doctor(s), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to any hospital reasonably accessible.

This authorization does not cover any major surgery unless the medical opinions of two other licensed physicians or dentists, concurring for such surgery, are obtained prior to the performance of such surgery.

_____ _____

PARENT / GUARDIAN SIGNATURE DATE

PART II: REFUSAL TO CONSENT

I do NOT give my consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the Coach or Recreation Board Member to take the following action:

_____ _____

PARENT / GUARDIAN SIGNATURE DATE