Champions Soccer Academy Camp
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New York, NY 10016
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347-731-4743

Medical and Immunization History - Programs and Camps

Please return to form to program:_____

_____

SECTION 1 *(To be completed by parent or guardian.)*

Name: _____ Sex: _____ Birth date: _____ (Month / Day / Year)

Address: _____ City/State/Zip: _____

Program name: _____ Program dates: _____

Father: _____ Phone (day): _____ Phone (evening): _____

Mother: _____ Phone (day): _____ Phone (evening): _____

Guardian is: ❑ father ❑ mother ❑ other (name and address): _____

(phone number): _____

Emergency contact (name, phone number, relationship to participant): _____

_____

Family physician name and address: _____

phone number: _____

Family dentist name and address: _____

phone number: _____

Medical insurance company: _____ Policy number: _____

In case of medical emergency, I hereby give permission to University Health Services (UHS) staff to hospitalize, to secure proper treatment for, and to order injection or minor surgery for my child, as named above.

_____ _____

Date Parent/guardian signature

Health care provider signature and/or stamp: _____

Printed name: _____

Address: _____

_____

Phone: _____ Date: _____