Po Box 1534
Concord MA 01742
Phone: 978-371-3355
Fax 978-371-3356

Email: info@gchockey.com

Medical/Camper Release and Contact Information **Camp #_____**

Campers Last / First Name:			**DOB:**
Address	City	State	Zip

Parent First / Last Name	**Cell #**	**Home / Work**
1.		
2.		
Camper Release: I (_____) parent/guardian will be picking up my child (above name) from camp every day.		

I authorize the following people below to drop off or pick my child (above name) up from camp. (If applicable)			
First / Last Name	Cell #	Relationship	Parent / Guardian Initial
1.			
2.			

Emergency Contact Information			
First / Last Name	Cell #	Home #	Relationship
1.			
2.			
3.			

Doctor's Name	Phone #	Dentist Name	Phone #

Health Care Provider	Plan #	Phone #

Liability Waiver and Medical Release

I agree that I shall provide health insurance to cover any personal injury and property damage sustained by the student while participating in any activities or while on the premises of the Greg Carter's European Hockey Training Camp Inc.; the undersigned assumes all responsibility for any and all risk for damage or injury that may occur to the above named player/s as a participant in Greg Carter's European Hockey Training Camp Inc. including practices, games, skill sessions, clinics, Summer Camps and other activities related to the program. In consideration of such, the undersigned hereby releases and discharge the program, Greg Carter's European Hockey Training Camp Inc., Greg Carter, it's operators, employees, agents, supervisors, instructors and other players from all claims, demands, rights or cause of action present or future, whether known or anticipated and resulting from or arising out of or incident to the undersigned participation with the said program. **This is also my permission to have my child admitted and attended to, for medical or dental treatment in case of sickness or injury.**

_____ _____

Signature of parent or guardian / player (18 older) Date

NOTE: This medical release is relative to scheduled Greg Carter's European Hockey Training Camp activities in the event the parent(s)/ guardian are not present to assure medical treatment if necessary.

Po Box 1534
Concord MA 01742
Phone: 978-371-3355
Fax 978-371-3356

Email: info@gchockey.com

Physical, Medical History and Immunization Camp's Name_____

You may also attach your child's health record with immunization to this form.

Medical History	
Medication	
Allergies	

Doctor's Name:	Date of Physical:

(physical to be within two years of the camp)

The Student may fully participate in the camp program with no restrictions. Yes / No (circle)

Immunization	Record Complete date (mm/dd/yyyy) of vaccine doses given
DTaP	
HPV	
Hepatitis A	
Hepatitis B	
Hib	
MMR	
Meningococcal	
Pneumococcal	
Polio	
Tdap	
Varicella	
Tetanus	

_____ _____

Physician's Signature Date

_____

Physician name (Print Name)

If the camper or staff member needs a prescribed medication during the camp, the following must be completed two weeks before the first day of camp: Written authorization signed by a parent or guardian, and written approval for the camp health care consultant to administer the medication.

I certify that my child has not incurred any significant health problem(s) since the date of the above physical examination.

_____ _____

Signature of parent or guardian / player (18 older) Date