Christy Moo Volleyball Camps - Winter Clinic
Minor or Adult Participant
(Please complete in blue or black ink)

NAME:____
Last First Middle

ADDRESS:____
Street City State Zip

DATE OF BIRTH:____
Month Day Year

HEALTH/ACCIDENT INSURANCE CARRIER:____

Policy Number:______________________________ Group Number:_______________________

Primary Physician:

____
Name Phone Number

Physician's Address:____
Street City State Zip

PARENT, LEGAL GUARDIAN, OR OTHER PERSON WHO HAS LEGAL AUTHORITY TO AUTHORIZE MEDICAL TREATMENT TO PARTICIPANT IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME:____

ADDRESS:____
Street City State Zip

TELEPHONE: HOME__________________ WORK_________________ CELL________________

Please list any chronic or acute medical problems (Continue on back if needed): ___________________

____

Please explain: ____

____

Please list any allergies: ____

List any medications being taken at present: ____

I ACKNOWLEDGE THE PARTICIPANT'S IMMUNIZATIONS ARE CURRENT: YES______ NO_______

I or MY CHILD plan to attend the Christy Moo Volleyball Camps Winter Clinic, hereinafter referred to as "CAMP." I fully realize that injury or illness could result from or during MY or MY CHILD'S participation in the CAMP. In case of accident or illness, I give my permission to receive medical treatment as deemed appropriate. I will assume responsibility for any medical bills.

Adult Participant or Parent/Legal Guardian's Signature

PLEASE PRINT CAMP PARTICIPANT NAME: ____

IF MINOR PLEASE PRINT PARENT'S NAME: ____
PLEASE PRINT EMERGENCY CONTACT NAME AND PHONE NUMBER: _____________________________