PLAYER PROFILE FORM

Please bring this form to "check-in" on the first day of camp. This form **must** be brought with you to "check-in" along with your medical form on your first day of camp.

Camp Session: _____ ++++++++++++++++++

Name: _____ + +

Birth Date: _____ Age at Camp: _____ ATTACH PHOTO HERE

Height: _____ Weight: _____ + +

Vertical Jump (if known): _____ ++++++++++++++++++

Camps attended in the past and when: _____

# of Years, Soccer playing experience: _____ Position most played: _____

Brief experience of soccer playing experience (include school and play): _____

_____

_____

The goals and objectives you hope to achieve throught attendance at No.1 Soccer Camps:

_____

_____

Special concerns/situations that No.1 Soccer Camps should be aware of: _____

_____

_____

_____

Youth Camp Health Exam/Record

No. 1 Soccer Camps • Medical Form

Please bring this form to "check-in" on the first day of camp.

www.no1soccercamps.com

Campsite and Dates Attending: _____

Last Name: _____ First Name: _____ Age: _____ Birth date: _____

Address: _____

City/State/Postal Code: _____ Name

of Parent or Guardian: _____Telephone: _____ Emergency

Contact: _____ Telephone: _____

Date of Arrival at Camp: _____Departure Date: _____

Date of Exam: _____ Height: _____ Weight: _____

Identify any known medical or emotional illness or disorder that would currently pose a risk to others or which would currently affect the individual's functional ability to participate safely: _____

_____ Medical

information pertinent to routine care and emergencies: _____

_____

Is this individual taking prescription medication? ❍ YES ❍ NO

If yes, indicate prescription: _____

Does the individual have allergies? ❍ YES ❍ NO Explain: _____

Is the individual on a special diet? ❍ YES ❍ NO Explain: _____

Can the individual self-administer medication? ❍ YES ❍ NO Explain: _____

IMMUNIZATION RECORD: (month, day, year for each dose)

Immunization	**Date**	**Date**	**Date**	**Date**	**Date**	**Immunization**	**Date**
	1st dose	2nd dose	3rd dose	4th dose	5th dose		
DTP/DtaP/DT						MMR (1ST dose)	
OPV/1PV						Measles (2nd dose)	
Hib (Haemophilus Influenza Type B)						Varicella (Chicken Pox) (Recommended)	
Hepatitis B						Other (Specify)	

Are there medical contraindications to immunization? ❍ YES ❍ NO If yes, specify the vaccine(s) and indicate the contraindications specified in the vaccine manufacturers' package insert that applies. _____

_____

Does this individual have laboratory confirmed proof of immunity to natural infection? ❍ YES ❍ NO If yes, please explain and attach laboratory report: _____

Is this individual current or in progress with immunizations according to the schedule adopted by the Commissioner of Public Health?

❍ YES ❍ NO Next appointment for Immunizations is scheduled for: _____

Month/Day/Year

Special Attention:

Mononucleosis within two months of camp activity is a contraindication to participation in the program.

The above named person is in satisfactory condition and may engage in all camp activities except as noted.

Medical Care Provider
(Name, Address, Telephone)

_____
Signature of MD, APRN or PA

_____
Date Form Signed

Attention Parent/Guardian:

Campers may not be permitted to participate in camp activities without a medical form signed by both parent/guardian and physician. In addition, campers may be refused medical treatment at local medical care facilities if medical form is not complete, insurance information is not provided and parent/guardian permission has not been granted. Please give these important details your utmost attention.

Medical/Accident Insurance: This form will not be accepted unless the following medical/accident insurance information is completed:

Medical/Accident Insurance Company: _____

Policy Number: _____

Policy Holder: _____

Social Security Number of Policy Holder: _____
(Parent/Guardian)

Employer's Name: _____

Parent/Guardian Authorization: (required for all persons under age 18) This health history is correct so far as I know, and the person named above has my permission to participate in all camp activities except as noted by me or the examining physician. I hereby give my permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for and order injection, anesthesia for surgery for the person named above. I hereby authorize the staff at No. 1 Goalkeeper's Camp, Inc. (DBA No. 1 Camps) to act according to their best judgement in an emergency requiring medical attention, and hereby waive and release the Camp and its staff from any and all liability for any injuries incurred while at camp. All medical expenses incurred will be the responsibility of the camper or the camper's parent/guardian. The camp is not responsible for personal items that are lost, stolen or damaged. I understand and accept the No. 1 Camps cancellation and refund policy. In addition, I give permission for my son/daughter to be taken off the campsite for supervised outings (professional soccer games, etc.) and agree that No. 1 Camps may use any photograph or video taken at No. 1 Camps for promotional purposes.

_____ _____
Signature Date

_____
Print Name