UNITED SPEED CLINIC

Builders of Speed, Strength, and a Healthier Soccer Athlete

Bordentown Soccer Club Wide Camp
TRAVEL AGE PLAYERS U8 +
Mon June 28 to Thurs July 1
6:00 – 8:00 pm
PEANUT AGE PLAYERS (U5 – U7)
Mon June 28 to Wed June 30
6:30 – 8:00 pm
Friendship Fields

513 Buttonwood Drive
Lanoka Harbor, NJ 08734
609-618-3723
CoachWElias@aol.com
www.UnitedSpeedClinic.com
Administrative Inquires
PeggyK@Unitedspeedclinic.com

First Name ____________________ *Last Name* ____________________ *Camp Location* _________________ *Date of Camp* ____/____/____

Date of Birth ____/____/____ *Age* _______ *Sex* _______ *Program* *Peanuts (U5 – U7). $55.00* *Travel Age (U8 +).$65.00*

Team Age (ex. U-8) _______________________ *Team Town* ___________________________ *Team Name (ex. United)* _______________________

Address ____ *City* ____________________ *State* ________ *Zip* _________________

*E-mail Address (**most info will come through e-mail**)* ____

Home Phone # (______)______-__________ *Cell/Work Phone # (______)______-__________*

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Health Information

Name of Personal Physician ____ *Phone # (______)______-___________*

Personal Health Insurance Carrier ____ *Policy #* __________________________
Group # __________________________

Check all items that apply, past or present, to camper's health history. Explain any "yes" answers.

Asthma	***yes no***	*Diabetes*	***yes no***	*High Blood Pressure*	***yes no***
Attention Disorder Deficiency	***yes no***	*Digestion*	***yes no***	*Kidney Disease*	***yes no***
Cancer/Leukemia	***yes no***	*Heart Trouble*	***yes no***	*Mental Illness*	***yes no***
Convulsions/Seizures	***yes no***	*Hemophilia*	***yes no***	*Lungs*	***yes no***
Eyes/Ears/Nose/Throat	***yes no***			*Takes Prescriptions Daily*	***yes no***

Explain ____

Allergies: Food, medicines, insects, plants ***yes no*** *Explain* ____

Name of Parent or Guardian ____

Emergency Contacts: *Name* ________________________________ *Relationship* ___________________________________
Phone # (______)______-__________ *Cell/Work Phone # (______)______-__________*

Name ________________________________ *Relationship* ___________________________________
Phone # (______)______-__________ *Cell/Work Phone # (______)______-__________*

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In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the physician selected by the adult program coordinator in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

Date ____/____/____ ***Signature of Parent/Guardian or Adult*** ____