Rockland GAA Summer Camp Registration/Medical Release Form

July 17th -21st 2017 Football + Hurling (5-12yrs): Rockland (9am – 2pm) ***www.rocklandgaa.com***

Player Name________________________

Approx Kit Size: Age 6 ____ Age 8 ____ Age 10 ____ Age 12 ____ Age:14 ___

Parent Name_________________

Football &Hurling/Camogie $ 150 for first child (additional Kids $120)

Checks Payable to Rockland GAA –Mail to; Joe Mc Girl 57 Tweed Blvd, Nyack NY 10960

Player's Name: __________________________________ Date of Birth: _________________________

Address: _____________________________ City:____________ State:____________Zip:_________

Did you participate in CUL CAMP NYC 2016? ___________ Ref Payment-:__________________

Payment (please tick): Cash ☐ Check ☐ Total 2017 Amount Paid__________

EMERGENCY INFORMATION (PLEASE INCLUDE AREA CODE)

Father's Name: __________________ Home Phone:__________________Cell Phone:_____________

Mother's Name: ________________ Home Phone: _________________ Cell Phone: ______________

Email address to receive notifications on Summer Camp to________________________________

In an emergency, when parents cannot be reached, please contact:

Name:__________________ Home Phone: __________________________Work Phone:______________________

Allergies:____

Other Medical Conditions: ____

Player's Physician:____

Work Phone: ____________________________ 2nd Phone:___________________________

Medical and/or Hospital Insurance Company: ______________________________________ Phone:.

Policy Holder: _______________________ Policy #: ___________________Group #:__________

PLEASE COPY BOTH SIDES OF YOUR MEDICAL INSURANCE CARD AND *ATTACH TO THIS FORM*

PARENT'S APPROVAL AND MEDICAL RELEASE

Recognizing the possibility of physical injury associated with Gaelic Football and in consideration for the New York Minor Board and its affiliates accepting the registrant for participation in its program and activities. I hereby release, discharge and/or otherwise indemnify Rockland GAA, its affiliated organizations and sponsors, their employees and associated personnel, including the owner of fields and facilities utilized for the Programs against any claim by or on behalf of the registrant as a result of the registrant's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize. My son/daughter has received a physical examination by a physician and has been found physically capable of participating in the Programs. I hereby give my consent to have the manager and /or doctor of medicine or dentistry provide my son/daughter with medical assistance and/or treatment and agree to be responsible financially for the reasonable cost of each assistance and/or treatment.

Signature of Parent__________________ _ **Can you volunteer time (Y / N) Dates available:**