

2010 AL GOLDEN FOOTBALL CAMP, LLC

CAMPER INFORMATION

RELEASE

CAMPER HEALTH FORM

LAST NAME	FIRST NAME	MI	
ADDRESS: STREET		CITY	
STATE	ZIP	CELL PHONE	HOME PHONE
SCHOOL (FULL NAME)/GRADE IN FALL '10			
T-SHIRT SIZE	HEIGHT	WEIGHT	DOB

EMAIL ADDRESS – THIS WILL BE HOW YOU RECEIVE CONFIRMATION AND ALL ADDITIONAL CAMP INFORMATION.

Offensive Position (Circle One) OL TE RB WR QB
 Defensive Position (Circle One) DL LB DB

CAMP SESSION

INSTRUCTIONAL CAMP – GRADES 6-12

\$55 PER CAMPER – (CHECK BOX TO LEFT OF DATE)

MAY 30 JUNE 6 JUNE 19 JUNE 24 JUNE 27

DIAMOND STREET DOUBLE

CHECK THIS BOX AND SELECT ONE (1) ADDITIONAL CAMP DATE AND PAY JUST \$25 MORE!

PAYMENT

Please send payment with your application

PAYMENT BY: CHECK MONEY ORDER

TOTAL AMOUNT ENCLOSED: \$ _____

NOTE: Make checks payable to the “AL GOLDEN FOOTBALL CAMP”. Please send check and application to:

AL GOLDEN FOOTBALL CAMP, LLC
 1001 W. DIAMOND STREET
 PHILADELPHIA, PA 19122

I the undersigned, individually and as parent and guardian of _____, a minor, agree that my child may participate in the Al Golden Football Camp (“Camp”). In consideration for permitting my child to so participate, I do hereby agree to fully release, discharge and hold harmless Al Golden, individually, the Camp and TEMPLE UNIVERSITY, including all managers, coaches, organizers, sponsors, supervisors, employees or contractors, from any and all liability for any and all injuries my child may incur during the participation in the Camp. I understand that my execution of this Release is a pre-condition to my child's acceptance and participation in the Camp. I do hereby further agree to indemnify and hold harmless Al Golden, individually, and the Camp, including all managers, coaches, organizers, sponsors, supervisors, employees or contractors in any action arising out of participation of my child in the Camp.

MEDICAL TREATMENT AUTHORIZATION

In case of an emergency, I understand that every attempt will be made to contact me. If contact is unsuccessful, I give my permission to any attending physician and medical service personnel to tender medical treatment to my child, _____, including (if necessary) hospitalization. I understand further that any expense arising from injury shall be my responsibility. I hereby authorize the staff of the Camp to provide care that includes routine diagnostic procedures (i.e., x-rays, blood and urine tests) and medical treatment as necessary to my child, _____ a minor. In the event that an illness or injury would require more extensive evaluation, I understand that every reasonable attempt will be made to contact me. However, in the event that an emergency occurs, and if I cannot be reached, I give my consent for physicians and staff at Temple University Health Services to perform any necessary emergency treatment.

I agree to the release of any records necessary for treatment, referral, billing or insurance purposes to the appropriate medical care provider. Accident insurance for the Al Golden Football Camp is provided on an excess basis. All registrants must have their own primary medical insurance. Any medical claims will be the primary responsibility of the parent or guardian's medical coverage on an as needed basis.

Parent/Guardian Name (Print) _____ Emergency Contact Number _____

Parent/Guardian Signature _____ Date _____

I understand that the consent and authorization herein granted do not include major surgical procedures and are valid only during the camp. Physical conditions that the clinician should be aware of (allergies, recurring illness, disabilities, chronic illnesses, current medications include:

CHECK ALL THAT APPLY

<input type="checkbox"/> Asthma	<input type="checkbox"/> Concussions
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Diabetes	

Allergies to drugs: _____
 Last Physical Examination (date): _____
 Last Tetanus Immunization (date): _____
 Current Medications: _____
 Chronic or Recurring Illnesses: _____
 Operations/Injuries (including dates): _____

Physical Restrictions: _____
 Physician Name/Phone #: _____
 Dentist Name/Phone #: _____
 Name of Insurance: _____
 Policy Number: _____
 Name of Employer: _____
 Employer Phone Number: _____
 Name of Policy Holder: _____

Parent/Guardian Signature _____ Date _____



Chodoff Field at Edberg Olson Hall – “Home of the Owls”

REGISTRATION FORM