After registering for a camp, please complete and send in the following form.

This form must be completed prior to participation in all Altitude Hockey Camps.

Mail the completed form to:

Email the completed form to:

Kolby_Green@uml.edu

Medical Release and Contact Information

General Information

Name:_____DOB:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Parent's Names: _____&_____
Home Phone:_____ Work Phone:_____ Work Phone 2:_____
Cell Phone:_____ Emergency Phone:_____

Emergency Contact Information

Contact Name:_____Relationship:_____
Contact Name:_____Relationship:_____
City:_____ State:_____ Zip Code:_____
Home Phone:_____ Work Phone:_____ Work Phone 2:_____
Doctor's Name:_____ Office #:_____
Dentist's Name:_____ Office #:_____
Other's Name:_____ Office #:_____
Health Care Provider:_____ Plan # _____ Phone #: _____

Travel Information

Hotel Name _____ Hotel Phone _____ Room #_____

Liability Waiver and Medical Release

I agree that I shall provide health insurance to cover any personal injury sustained by the student and property damage while participating in any activities or while on the premises of the hockey camp provided by Altitude Hockey Camps, LLC; (the "Camp"). The undersigned assumes all responsibility for any and all risk for damage or injury that may occur to the above named player/s as a participant in the Camp, including practices, games, skill sessions, clinics, and other activities related to the Camp. In consideration of such, the undersigned hereby releases and discharge Altitude Hockey Camps, LLC, its members, owners, operators, employees, agents, supervisors, instructors and other players from all claims, demands, rights or cause of action present or future, whether known or anticipated and resulting from or arising out of or incident to the undersigned's participation with the said Camp. This is also my permission to have myself or my child admitted and attended to, for medical or dental treatment in case of sickness or injury.

_____ _____

Signature of parent or guardian / player (18 older) Date

NOTE: This medical release is relative to scheduled Altitude Hockey Camps, LLC., activities in the event the parent(s)/ guardian are not present to assure medical treatment if necessary.

Medical History

Allergies: _____

Chronic Medical Problems: _____

Medication/Treatment: _____

Dietary Restrictions: _____

If the camper needs a prescribed medication during the camp, the following must be completed two weeks before the first day of camp: Written authorization signed by a parent or guardian, and written approval for the camp consultant to administer the medication.

I see no reason to restrict full participation in hockey camp. I certify that my child has not incurred any significant health problem(s) as of the date hereof.

Parent's Signature: _____

Date_____

Address _____