

All - Court Tennis – Updated (2010) General/Medical Release Form

GENERAL: In registering my child as a participant in the All-Court Summer Camp series, I understand my child assumes any and all risks which might be associated with its activities and waive and release all rights and claims for damages which my child, heirs, executors, administrators, assigns, or I may have against All- Court Tennis Camps and Clinics, its director, coaches, or representatives, for any and all injuries or damages of any kind suffered as a result of participation in All-Court Summer Camp series.

PHOTOGRAPHY: I also DO/ do NOT (circle one) authorize All-Court to take, use, publish, and reproduce photographs, moving pictures, slides, or videotapes of my child for its teaching, documentation, or public relations program.

Signature of Parent/Guardian: _____ Date: _____

MEDICAL: I, _____, the Parent/Guardian of _____, give my consent for emergency first-aid/ medical/surgical treatment of my child in the unlikely event that medical attention may be necessary.

Signature of Parent/Guardian: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____.

Work Phone: _____ Cell Phone: _____

Additional Contact Person, in emergency (Required): _____.

The following is a designed to help you in giving the Health History of your child as required by Massachusetts state law. All information is kept strictly confidential, unless it is necessary to share with relevant counselor(s) who will be working with your child.

Frequent Ear Infections	<input type="checkbox"/>	Heart Defects/Disease	<input type="checkbox"/>
Convulsions/Epilepsy	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Bleeding/Clotting Disorders	<input type="checkbox"/>	Mumps	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>
Psychiatric Treatment	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	Measles	<input type="checkbox"/>
German Measles	<input type="checkbox"/>	Other: _____	

Does your child suffer from any allergies (food, insect stings, etc.) that could be problematic while he/she is at camp? (Y / N) If yes, please describe allergen, typical reaction, and treatment: _____

Please describe any other restrictions and treatments your child may require, or if your child is affected by any of the following: Disability, Recurring of Chronic Illness, Psychiatric Problems, etc. _____

Physician's Name: _____ Phone: _____

Insurance Provider: _____ Policy No. _____