# Elite Goalies 2012 Registration Form

## Athlete Details

First Name: ________________________ Last Name: ____________________________

Birthdate: _______________________________

Gender: ___________

## Athlete Contact Information

Email: _______________________________________________________

Phone Number 1: ______________________________________________

Phone Number 2: _______________________________________________

## Athlete Address

Address 1: _______________________________________________________

City: ________________________ State:_________ Zip: _______________

## Current Team Information

Team Name: _______________________________________________________________

Team's Level of Play: _______________________

## Guardian Information

Parent/Guardian First Name: ______________________________________________

Parent/Guardian Last Name: _______________________________________________

Parent/Guardian Email: __________________________________________________

Parent/Guardian Phone: __________________________________________________

## Camp Selection

Please check the Camp(s) that the Participant is registering for:
*See the Elite Goalies Website for more information on each camp.*

***Elite Goalies Prospect Camp Dates:***

**July 12th-15th, 2012: Madison, WI**
____2:1 – Student/Teacher Ratio ($999.00) or ___3:1 – Student/Teacher Ratio ($699.00)

***Elite Goalies High Performance Camp Dates:***

**July 12th – 15th, 2012: Madison, WI**
____ 2:1 - Student/Teacher Ratio ($775.00) ____ 3:1 - Student/Teacher Ratio ($550.00)

**July 17th-20th, 2012: Madison, WI**
____ 2:1 - Student/Teacher Ratio ($775.00) ____ 3:1 - Student/Teacher Ratio ($550.00)

***Elite Goalies Initiation Camp Dates:***

**July 25th-27th, Madison, WI**
____ 2:1 - Student/Teacher Ratio ($550.00) ____ 3:1 - Student/Teacher Ratio ($375.00)

## Payment

Please make checks payable to:

**Elite Goalies**
**5526 Blazing Star Road**
**Frisco, TX**
**75034**

A confirmation will be emailed once check has been received.

****** Note: You may choose to secure your spot with a $200 deposit. The remainder of your payment will be due 30 days prior to camp.***

****** Note: Please include your signed medical form with your check.***

**Elite Goalies Inc.**
**PART ONE:**
***CONFIDENTIAL CONSENT FOR MEDICAL TREATMENT***

**TO THE PARENT(S) OR LEGAL GUARDIAN:**
If your son, daughter, or ward will be **under** the age of 18 years while at our camp, it is our policy to secure your consent for medical treatment.
• By signing below you give your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
• By signing below you are stating that you are aware of and accept the risk inherent in the program activity.
• By signing below you agree to hold harmless and indemnify Elite Goalies Inc. and it's employees from any and all liability, loss, damages, or expenses which are sustained, or required arising out of the actions of your dependent in the course of the this camp or clinic.

____________________________________ ____________________________________ ____________________

**PARTICIPANT NAME (Please Print)** **SIGNATURE OF PARENT OR LEGAL GUARDIAN** **DATE**

## *CONFIDENTIAL CONSENT FOR MEDICATION ADMINISTRATION*
**(Please include over the counter medications)**

If your son, daughter, or ward will be **UNDER** the age of 18 while at the Elite Goalies Inc., it is a **Wisconsin State Law** to secure your consent for medication distribution and for the use of medical devices (this also includes all over the counter medications brought to camp). The medication or medical device can be self-administered (**if over 18**) or be administered by the Health Services Staff.

All medications **must be in a medicine bottle and labeled** with the camper's name, doctor's name and phone number, medication name, prescription number, date prescribed and dosage. You must also complete the form below: **(Make sure to mark one of the following below)**

______ No medication has been brought to camp.
______ I want the medication or medical devices self-administered. (**Age 18 and above only**.)
______ I want the medication or medical device administered by the Health Services Staff. However, a limited amount of medication for life threatening conditions should be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

Name of Medication (s) ________________________________________________________________________________

Prescription # ____ ________________________________________________________________________________

Prescribing Physician Physician's Phone
#________________________________________________________________________________

Date Prescribed Amount to be taken When to be administered Day(s) to be taken:

________________________________________________________________________________

Possible adverse reactions Specific conditions when physician should be contacted

________________________________________________________________________________

Name of Medication (s)
_______________________________________________________________________________
_____

Prescription # ____
_______________________________________________________________________________
__________

Prescribing Physician Physician’s Phone
#________________________________________________________________________

Date Prescribed Amount to be taken When to be administered Day(s) to be taken:

_______________________________________________________________________________
___________________________

Possible adverse reactions Specific conditions when physician should be contacted

_______________________________________________________________________________
___________________________

**(ALL MEDICATION INFORMATION MUST BE COMPLETED IN FULL)**

Special Instructions

Full Legal Participant:

Full Home Address:

Street:

City: State: Zip:

Home Telephone Number:

Date of Birth: ____/____/_____ Sex: M F

Parent/Guardian Name: Relationship:

Parent Cell #: Parent/Guardian Work Telephone:

Does participant have allergic reactions to:

☐ Yes ☐ No ................ Penicillin

☐ Yes ☐ No ................ Other Antibiotics __________________

☐ Yes ☐ No ................ Other Medicine (type) _____________

☐ Yes ☐ No ................ Insect Bites/Stings ________________

☐ Yes ☐ No..................Food Products ____________________

Does participant take medication on a regular basis?

☐ Yes ☐ No If Yes, Identify _______________________
**(consent for medication administration must be signed on reverse.)**

Alternate contact in the event that the Parent/Guardian cannot be contacted during an injury or illness:

Name:

Relationship:

Address:

Telephone Number:

Physician: ______________________________________ Telephone:____________________

Policyholder's Name:____________________________ Group No.:____________________

Insurance Co.: _____________________________Subscriber or Policy No.: _______________
(Copy of insurance card not required)

Has participant had or presently experiencing:

☐ Yes ☐ No - Allergies (including food products)

☐ Yes ☐ No - Asthma

☐ Yes ☐ No - Bleeding Disorder

☐ Yes ☐ No - Cancer

☐ Yes ☐ No - Colitis

**Immunization Record**

☐ Yes ☐ No - Diabetes
☐ Yes ☐ No - Epilepsy/Seizures/Blackouts
☐ Yes ☐ No - Heart Disease
☐ Yes ☐ No - Hernia
☐ Yes ☐ No - High Blood Pressure
☐ Yes ☐ No - Tetanus boost within the last 10 years
☐ Yes ☐ No - Joint Injury/Surgery
☐ Yes ☐ No - Kidney Disease

☐ Yes ☐ No - Has participant ever had major surgery or been hospitalized?
☐ Yes ☐ No - Menstrual Difficulties
☐ Yes ☐ No - Mental/Emotional Problems
☐ Yes ☐ No - Neck/Back Pain/Injury
☐ Yes ☐ No - Rheumatic Fever
☐ Yes ☐ No –Tuberculosis
☐ Yes ☐ No - Ulcer

Please explain any significant operations, accidents or illnesses, and last medical attention and reason:

Does the participant have any physical condition(s) requiring special considerations? Explain. Other:
_______________________________________________

**A physical examination within 24 months of the camp/event is recommended, not required.**

Date of participant's last physical examination:_______________________________