COMBS HIGH SCHOOL
FOOTBALL CAMP
JULY 6-10, 2008

MAKE CHECKS PAYABLE TO COMBS FOOTBALL: $245

PAY AT BOOKSTORE:

Payment plan available

PAYMENT DUE: APRIL 6TH

Name____ DOB___________

Address____

City______________________ Zip___________ Home Phone___________

Emergency Contact and Phone____________________________________

HEALTH QUESTIONS:

Do you take any medications?______ If yes, what medications are needed________________

Allergies?________ If yes, what medications are needed___________________

Any chronic health problems?_______If yes, what?________________________

Medical/Civil Liability Release Form

I, __________________________________, the legal guardian of _________________________________ authorize the Combs High School Staff and those associated with the camp to administer general first aid treatment for any minor injuries received to my athlete during camp. If the injury sustained is life threatening, or in need of emergency treatment, I authorize Combs High School or its representative to summon any or all professional emergency personnel to attend, transport and treat my athlete.
If the injury sustained requires hospitalization, I understand that I or my medical insurance company is solely responsible for claims/bills that may be filed as a result of the injury. By signing this medical release form, I further understand that I will not file any civil liability lawsuit against Combs High School, its representatives or J.O. Combs Unified School District #44 as a result of any injury sustained to my athlete during this camp.

Parent/Legal Guardian Signature____

Medical Insurance Information:

[ ] I DO have medical insurance for my athlete and I agree to be responsible for all costs that my medical insurance does not cover.

Primary Insurance Company___________________________ ( )Phone________________________

Policy Holder__________________________ Relationship to athlete____________________________

Policy/Membership Number__________________________Group Name/#________________________

Effective Date of Coverage__________________________