

**2021
CAMP APPLICATION
PAGE 1**

**WESTERN NEW ENGLAND
SOCCER ACADEMY**

CAMP DATES ATTENDING

- 7/5 - 7/9
 7/12 - 7/16

*According to Massachusetts General Law 105 CMR 430.000 ALL CAMPERS MUST SUBMIT, IN COMPLETION, BOTH SIDES OF THIS HEALTH FORM or a Health Care Recommendation form by a Licensed Medical Provider.

NOTE! INDICATE T-SHIRT SIZE: YL AS AM AL AXL

CAMP TUITION: \$270

SECTION I (to be completed by Parent/Guardian)

PARTICIPANT: M F

Email Address: _____ *All Camp Correspondence will be sent by email - Please PRINT

Name: _____ Birth Date: _____
First Middle Last Month Date Year

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

Guardian Is: Father _____ Mother _____ Other _____ Guardian Name: _____

Guardian Phone: (Day) _____ Guardian Phone: (Evening) _____

Guardian Address (if different) _____ City _____ State _____ Zip _____

In case of illness or emergency the name and telephone number of a person to contact: (Relative of Participant)

Name: _____ Relationship: _____ Telephone Number: _____

SECTION II: Family Physician or HMO:

Name: _____ Address: _____

City: _____ State _____ Zip _____ Telephone: (Day) _____

Family Dentist:

Name: _____ Address: _____

City: _____ State _____ Zip _____ Telephone: (Day) _____

Medical Insurance Company: **REQUIRED – NOTE! PLEASE SIGN BOTH SECTIONS BELOW!!!**

Company: _____ ***Policy Number: _____

In case of medical emergency, I hereby give permission to the Camp Certified Athletic Trainer to hospitalize, to secure proper treatment for, and/or to order injection or minor surgery for my child as named above.

SECTION II: CAMP ACTIVITIES AUTHORIZATION

I/We, the undersigned, for ourselves, our heirs, executors and administrators, waive, release and forever discharge The Western New England Soccer Academy, Western New England University, and its staff, officers, agents, employees, representatives, successors and assignees of and from all rights and claims for damages, injuries, or loss of person or property which may be sustained or occur during participation in Camp activities or while at camp.

Parent Signature **REQUIRED ABOVE** Date

Parent Signature **REQUIRED ABOVE** Date

Please Print and Complete BOTH (2) PDF Application Forms
Mail With Check Made Payable To: Western New England Soccer Academy
114 Evergreen Drive East Longmeadow, MA. 01028

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SECTION III: Physical Examinations

(Must have been done by a medical provider within the preceding 24 months).

Medical History: (Please note significant disorders)

Allergies _____ Heart _____ Tuberculosis _____
 Kidney _____ Lung _____ Diabetes _____
 Varicella _____ Disabilities _____ Neurological _____
 Whooping Cough _____ Other: _____

Pertinent Medical History: _____

Child Name: _____ Birth
 Date: _____ Summary
 of Significant Treatment Program including Names/dose of Medications
 to be used while at program:

(Medications MUST be in a container with the original label)

Health Care Provider/Physician:

Signature and /or Stamp Required

Date: _____
 Printed Name: _____
 Address: _____
 City: _____
 State _____ Zip _____ Telephone: (____) _____

Person herein described has permission to engage in all prescribed camp activities
 EXCEPT as noted here:

SECTION IV: Immunizations

Has completed primary series of tetanus/diphtheria? (four doses)

Yes _____ No _____

Primary Series - Type of Vaccine OVP IPV E-IPV ____/____/____

Laser Booster - Type of Vaccine OVP IPV E-IPV ____/____/____

Immunization	Dates
Diphtheria/tetanus (Td) Must be within last ten years	____/____/____
Measles #1 (Rubella, Red measles) Must be AFTER age 12 months or	____/____/____
MMR #1 or Positive Measles Titer (Blood Test)	____/____/____
Measles #2 (rubella, Red Measles) Must be at least 30 days AFTER first dose or	____/____/____
MMR#2	____/____/____
Mumps or MM#1 Must be AFTER age 12 months or Positive Mumps Titer (Blood Test)	____/____/____
Rubella (German Measles) or MMR #1 Must be AFTER age 12 months or Positive Rubella Titer (Blood Test)	____/____/____
Hepatitis B - those born AFTER 1-1-92 Dose #1 Dose #2 Dose #3	____/____/____ ____/____/____ ____/____/____

Medical Exemption: The above named person does not have one or more of the required immunizations because she/he has medical problem (s) that precludes the _____ vaccine (s).

We Provide

Experienced Coaches • Indoor and outdoor facilities • Superior Soccer Fields • T-shirt for Every Camper* • Certified Athletic Trainer on Staff • Swimming Pool with Life Guards on duty • The most Instructional time of any area day camp! •

You Supply

An attitude to Learn! • Cleats or Sneakers • Shin Pads • Soccer Ball • Swim Gear and Towel • Indoor Shoes in Case of Rain.

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