

2008 Application
Kerr Camp and Coach O's Soccer TEAMS
Please make checks payable to: Coach O's Soccer TEAMS, LLC
Mail to: Kerr Camp, P.O. Box 920266, Needham, MA 02492.
Payment is due in full with application

NAME _____ Age ____ BOY ____ GIRL ____

GRADE (Entering next fall): _____ DOB _____

ADDRESS _____

CITY _____ STATE ____ ZIP _____

EMAIL _____
(Required for confirmation of application)

PHONE _____

PARENTS' NAME _____

WORK PHONE _____

EMERGENCY CONTACT _____

PHONE _____

BALL ____ Yes (\$25, please include payment) ____ No

CIRCLE T-SHIRT SIZE: YM YL XS S M L (ADULT SIZES)

Sessions – Check all that apply!

Needham Sessions (Boys & Girls 5-13):

____ June 23- 27, 9:00 AM TO 3:00 PM (Tuition: \$295)

____ August 11-15, 9:00 AM TO 3:00 PM (Tuition: \$295)

Waltham Sessions (Boys & Girls 7-17):

____ July 21- 25, 9:00 AM TO 4:00 PM (Tuition: \$295)

____ July 28- August 2, 9:00 AM TO 4:00 PM (Tuition: \$295)

Please email coachosoccer@yahoo.com for information on half days.

For Office use only:

Ck # _____ Amt _____ Med _____ Sig _____ Conf _____

CONSENT TO MEDICAL TREATMENT OR CARE

Please submit medical records signed by a licensed health care provider, including health history, evidence of a physical exam within the past 24 months and immunization records.

Health Insurance Provider _____

Policy number _____

Primary Care Physician _____

Physician's Phone _____

Camper's Allergies _____

I hereby release Kerr Camp & Coach O's Soccer TEAMS from any and all claims and liability of any kind of personal injury or property damage due to participation in this camp. I certify that my child is in good health and is able to participate in physical activities, including soccer. I understand that the soccer camps rent the facilities from Harvard and are not sponsored by Harvard University.

In the event of illness or injury, I grant Kerr Camp & Coach O Soccer TEAMS the right to take appropriate action for my child's health and safety and to obtain any necessary medical assistance. I will be fully responsible for all medical expenses incurred by my child while attending the program.

Written authorization to administer prescribed medications must be signed by the parent or guardian. This medication must be kept and administered by the health supervisor.

I understand that lost equipment and personal belongings are not the responsibility of the Camp.

If my child disobeys the Camp rules, I agree that my child may no longer be able to participate in the program and that the program will not refund any of the fees paid for attending the Camp.

Parents may request copies of background check, health care and discipline policies and procedures for filing grievances.

I have read and freely signed this agreement, which shall take effect as a sealed instrument.

_____ (Signature of Parent or Guardian) Date _____

AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER

Name of camper: _____ Age: _____

Name of Parent/Guardian: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Food or Drug Allergies: _____

Name of Doctor or Licensed Prescriber: _____

Business Phone: _____ Emergency Phone: _____

Name of Medication: _____

Dosage: _____ Frequency Of Dosage: _____

Directions for administration: _____

Reason for Medication: _____

Special Storage instructions: _____

Other Specific Directions (with food, etc.): _____

Possible side effects: _____

Please sign if Camper is allowed to administer the medication to him/herself (inhaler, advil, etc...): _____

I hereby authorize _____ to administer to my child _____
(name of camp) (name of child)

the above listed medication (s), in accordance with the 105 CMR 430.160.

105 CMR 430.160 (A)

Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.

105 CMR 430.160 (C)

Medication shall only be administered by the health supervisor or by a licensed health care professional authorized to administer prescription medications. The health care consultant shall acknowledge in writing the list of medications administered at the camp. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.

105 CMR 430.160 (D)

When no longer needed, medications shall be returned to a parent/guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

Parent/Guardian Signature: _____ Date: _____

Authorization for Alternative Person Pick-Up For Campers

I, _____ the Parent/Guardian of _____

(Name of Parent/Guardian) (Name of
Camper)

give permission for _____ to pick up
(Name of Non Parent/Non-Custodial Person)

_____ on _____ at _____
(Campers Name) (Date) (Time)

and bring him/her to _____
:

(Date of Signature)
Up)

(Signature of the Parent/Guardian Authorizing Pick
Up)