



CALLE MAIN G-5  
 TORRIMAR ESTATES  
 GUAYNABO, PR 00969  
 TEL- 787-946-5663  
 EMAIL: PRALLPRO04@YAHOO.COM

# REGISTRATION FORM 2010

Please Print clearly and mail *completed* registration and medical form to the address on the LEFT.

For Official Use only  
 Camper ID # \_\_\_\_\_

**REGISTER BY JULY 1<sup>ST</sup> TO ENSURE YOU HAVE A RESERVED SPOT  
 THIS IS A CLINIC YOU HAVE NEVER EXPERIENCED BEFORE! Equipment needed: T-shirt,  
 shorts and sneakers. CHECKS MUST BE MADE OUT TO: DIRK MORAN**

## CAMPER INFORMATION

FIRST NAME		LAST NAME		MI	DOB	AGE
ADDRESS			CITY	STATE	ZIP CODE	
EMAIL		HOME PHONE NUMBER		GENDER		
				M <input type="checkbox"/>	F <input type="checkbox"/>	
CAMP SESSIONS	PRICE	POSITION		Emergency Contact (Other than Parents)		
July 5-9 July 12-16	\$150.00/WK	OFFENSE		NAME		
		QB__ RB__ WR__ TE__ OL__		RELATIONSHIP TO CAMPER		
		DEFENSE		CEL PHONE		
		LB__ CB__ S__ DL__ DE__				

## FAMILY INFORMATION (PLEASE ATTACH ADDRESS INFORMATION IF DIFFERENT FROM ABOVE)

FATHER	FIRST NAME	LAST NAME	HOME PHONE	WORK PHONE
	CEL PHONE	FAX	EMAIL	
MOTHER	FIRST NAME	LAST NAME	HOME PHONE	WORK PHONE
	CEL PHONE	FAX	EMAIL	

## PAYMENT INFORMATION

CHECK  # \_\_\_\_\_

MONEY ORDER

**FINAL PAYMENTS  
 DUE BEFORE  
 JULY 1, 2010**

## TERMS & CONDITIONS

There is a cancellation fee of \$50.00 after payment is made. Also, after June 15, 2010 there will be no money refunded.  
 Clinic Director reserves the right to dismiss campers based on behavior, attitude and disposition. Also, participants can be dismissed based on the benefit of the child. **NO** refunds will be given to participants dismissed from clinics.  
**Complete terms and conditions:** By signing this agreement, parent consents the clinics to use the child's image for publicity (print or electronic) at its discretion. Also, you are certifying that applicant is in complete physical, mental and emotional health and can participate in all clinic activities and assume all risks involved with physical activity. Also, you understand with all terms and conditions and agree to abide by its terms. Finally, you understand that PRAPFC will supply proper supervision for your child but you assume all risks incidental with participation in the clinics and waive, release absolve, indemnify and agree to hold harmless PRAPFC, its directors, officers, coaches and personnel.

PARENT/ GUARDIAN SIGNATURE

DATE



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# MEDICAL FORM 2010

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 Camper ID # \_\_\_\_\_

## CAMPER INFORMATION

FIRST NAME	LAST NAME	MI	DOB	AGE
PARENT CEL PHONE		HOME PHONE NUMBER		GENDER M <input type="checkbox"/> F <input type="checkbox"/>
FAMILY DOCTORS NAME		DOCTORS PHONE		

## HEALTH INSURANCE AND HISTORY

Company _____	PRINCIPAL CARDHOLDER _____	EXPIRATION DATE Month ____ / Yr ____
Card Number _____		

## ATHLETE HEALTH HISTORY

1. HAS ATHLETE BEEN TREATED FOR A SERIOUS ILLNESS (ex. EPILEPSY)? YES \_\_\_ NO \_\_\_  
 IF YES, EXPLAIN \_\_\_\_\_

2. DOES PARTICIPANT HAVE ALLERGIES? YES \_\_\_ NO \_\_\_  
 IF YES, PLEASE DETAIL \_\_\_\_\_  
 Does he need an epipen? Yes \_\_\_ No \_\_\_  
 Does he react to allergen through ingestion or contact? Yes \_\_\_ No \_\_\_

3. DOES PARTICIPANT SUFFER FROM ASTHMA? YES \_\_\_ NO \_\_\_  
 IF YES, PLEASE DETAIL SEVERITY \_\_\_\_\_  
 MILD \_\_\_ MEDIUM \_\_\_ SEVERE \_\_\_  
 IF YES, PLEASE DETAIL MEDICATION USED \_\_\_\_\_

4. WILL PARTICIPANT BE USING ANY OTHER PRESCRIPTION MEDICATION? YES \_\_\_ NO \_\_\_  
 IF YES, PLEASE DETAIL TYPE/ DOSAGE/ FREQUENCY/ CONDITION \_\_\_\_\_

5. HAS THE PARTICIPANT EVER HAD SERIOUS INJURIES OR SURGERIES? YES \_\_\_ NO \_\_\_  
 IF YES, PLEASE DETAIL CONDITION/ DATE \_\_\_\_\_

6. IS THERE ANYTHING ELSE PRAPFC SHOULD BE COGNIZANT OF?  
 IF YES, PROVIDE DETAILS ADD ANOTHER SHEET IF NECESSARY \_\_\_\_\_

We will do everything possible to contact parents in case of accident or injury. It may be necessary to get immediate medical attention for your child and it may be impossible to contact you prior to doing so. Your signature below grants us permission to get immediate medical help should it be necessary.  
 I HEREBY CONSENT to the admission of the above named child in case of an emergency to the nearest local hospital as may be available, and I grant permission to the Doctor in charge to administer anesthetic or perform any other medical treatment deemed necessary.

PARENT/ GUARDIAN NAME	PARENT/ GUARDIAN SIGNATURE	DATE