



Mail to: Elite Lacrosse PO Box 99 Swampscott, MA 01907

**Section I: (TO BE COMPLETED BY PARENT OR GUARDIAN)**

**\*\*\* You must be a US Lacrosse Member to play for any Elite Gulls Lacrosse program.\*\*\***

US Lacrosse #-\_\_\_\_\_

Campers Name \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Father: \_\_\_\_\_ Day Tel: \_\_\_\_\_ Eve Tel: \_\_\_\_\_

Mother: \_\_\_\_\_ Day Tel: \_\_\_\_\_ Eve Tel: \_\_\_\_\_

Guardian is: Father  Mother  Other (Name): \_\_\_\_\_

Address: \_\_\_\_\_ Tel: \_\_\_\_\_

Name of Emergency contact (relation to camper): \_\_\_\_\_

Day Tel: \_\_\_\_\_ Eve Tel: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Tel: \_\_\_\_\_

Family Dentist: \_\_\_\_\_ Address: \_\_\_\_\_ Tel: \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION:** Campers must complete insurance information prior to arriving at camp.

Medical Insurance Company Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Section II: Camper Waiver and Release of Liability**

In consideration of being allowed to participate in the Elite Lacrosse Camp (the “camp”) sponsored by Elite Lacrosse, LLC. (“Company”) and related events and activities, the undersigned acknowledges, understand, and agrees that:

1. I hereby agree to behave in a responsible manner during any team events. I understand that anyone who does not follow the rules of the team I may be sent home.
2. The risk of injury from the activities involved in the program of the team is significant, including potential for permanent paralysis and death, and while particular rules, equipment, and personal discipline may reduce the risk, the risk of serious injury does exist; and
3. I knowingly and freely assume all such risks, both known and unknown, even is arising from the negligence of the company, its officers, shareholders, directors, officials, agents, coaches and or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the camp (the “releases”\_ and I assume full responsibility for my participation; and
4. I willingly agree to comply with the stated and customary terms and conditions for participation. If, however, I observe any unusual significant hazard during my presence or participation, I will remove myself from participation and bring such attention of the nearest staff/official immediately; and
5. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, hereby release and hold harmless the releaseses with respect to any and all injury, disability, death, or loss, or damage to person or property, whether arising from the negligence of the releaseses or otherwise unless caused by the willful, wanton and intentional conduct of the releaseses.

I have read the release of liability and assumption of risk agreement, fully understand and it' terms, understand that I have given up substantial rights by signing it, and sign it freely and voluntarily without and inducement.

You must be a member of US Lacrosse to participate in any team practices, games or tournaments. Please provide you US Lacrosse Membership number below>

US Lacrosse Membership # \_\_\_\_\_

X(Player's Signature) \_\_\_\_\_ Date Signed: \_\_\_\_\_

This is to certify that I, as parent/guardian with legal responsibility for this camper, do consent and agree to his foregoing waiver and release of all the releases, and, for myself, my heirs, assigns, and next of kin, I release and agree to indemnify the releases from any and all liabilities incident to the camper's involvement or participation in the camp as provided above.

X(Parent/GuardianSignature) \_\_\_\_\_ Date Signed: \_\_\_\_\_

### **Medical and Immunization History**

#### **Section III: Physical Examination**

**(MUST BE IN THE PRECEDING 12 MONTHS AND DONE BY A MEDICAL PROVIDER)**

Medical History (Please not significant disorders):

Allergies: \_\_\_\_\_ Heart: \_\_\_\_\_ Tuberculosis: \_\_\_\_\_

Kidney: \_\_\_\_\_ Whooping: \_\_\_\_\_ Cough: \_\_\_\_\_

Diabetes: \_\_\_\_\_ Lung: \_\_\_\_\_ Varicella: \_\_\_\_\_

Disabilities: \_\_\_\_\_ Neurological: \_\_\_\_\_ Other: \_\_\_\_\_

Pertinent Medical History: \_\_\_\_\_

Summary of Significant Treatment Program, including Names/Dose of Medications to be used while at camp:

(Medications MUST be in airtight container with the original label): \_\_\_\_\_

#### **Section IV IMMUNIZATIONS: Required through the Board of Health**

***HEALTH CARE PROVIDER SHOULD ATTACH A COPY WITH A HEALTH CARE PROVIDERS SIGNATURE OR STAMP***