



FORMAN

12 Norfolk Road, P.O. Box 80 • Litchfield, CT 06759 • www.formanschool.org • 860.567.8712 • fax 860.567.8317

FORMAN LION SUMMER CAMPS/CLINICS REGISTRATION

Child's Name _____ Age _____ DOB _____ Gender _____

Address: _____

Please register my child for the following(check the camp/clinic of choice):

- Forman Lion Baseball Camp (7-10 year olds)
- Forman Lion Baseball Camp (11-14 year olds)
- Forman Lion Girls Basketball Clinic (11-14 year olds)
- Forman Lion Boys Basketball Clinic (11-14 year olds)

PARENT/GUARDIAN INFORMATION	PARENT/GUARDIAN #1	PARENT/GUARDIAN #2
Name		
Street Address		
City or Town		
Zip code		
Home Phone #		
Cell Phone #		
Email Address		

Permission Form/Release

Notice: Read this document carefully. This document affects your legal rights, and contains waivers and releases of your rights.

I, _____, give permission for my child _____ to participate in the Forman Lion Summer Camp/Clinic ("Camp") operated by the Forman School ("Forman"). I have read and understand the Program Description for the Camp and acknowledge that this program is a voluntary recreational activity that I have determined is appropriate for my child's age and abilities.

In signing below, I acknowledge that the camp/clinic activities will include athletic instruction and outdoor physical activity and I understand the nature of the activities and their inherent risks, including the potential for physical injury and exposure to unpredictable weather conditions. I further agree and acknowledge that my child's participation in these activities is voluntary and in signing below, I represent that my child is able to participate safely in these activities with or without any reasonable accommodations.

In consideration for being allowed to participate in the Camp, and with only those exceptions described below, on behalf of myself and my child, I fully ASSUME ALL RISKS, inherent and otherwise, whether or not described above, and RELEASE AND DISCHARGE the Forman School its officers, trustees, faculty, employees, agents or representatives under the direction and control of the School (the "School" or "Released Party") from any and all liability, damage, injury or loss, including bodily injury or death, arising from, related to, occurring during, or associated with my participation in the above event for any reason. These agreements of Assumption of Risk and Release do not apply if (1) the liability, damage, loss or injury is CAUSED BY THE NEGLIGENCE of the School and do not include the negligence or any other act or omission by any other person or entity, including me, as a participant in this activity; or (2) the liability, damage, loss or injury is CAUSED BY THE RECKLESS, WANTON or INTENTIONAL MISCONDUCT of the School.

I, the undersigned, further agree to defend, indemnify and hold harmless the School from any and all claims, lawsuits or demands made by anyone arising from or relating to my child's participation in the Camp, except for negligence caused solely by the School or the reckless, wanton or intentional misconduct of a Released Party.

This release of liability will be construed in accordance with Connecticut law.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN VOLUNTARILY.

Signature of Parent/Guardian

Date

MEDICAL AUTHORIZATION

In signing below, I hereby authorize the Forman School ("School") or its authorized representative to arrange for and provide routine care and treatment for my child's health needs or conditions, such as basic first aid, while my child is participating in the Camp/Clinic.

Signature of Parent/Guardian

Date

Printed Name of Parent/Legal Guardian:

Physical Exam Record

Patient Name _____ Date of Birth _____ Date of Exam _____
Last first middle initial

Height _____ Weight _____ Blood pressure _____

Allergies _____ Current Medications _____

System	Normal	Abnormal	Explanation of abnormal
HEENT			
Skin			
Lungs			If asthmatic, what is the Asthma Action Plan (AAP)
Heart			
Abdomen			
GU			
Musculoskeletal			
Extremities			
Neurologic			

Any serious injury or illness or neurologic disorder? _____

Any surgeries? _____

Any relevant psychiatric history _____

SPORTS EXEMPTION or Restriction: No _____ Yes _____ Details _____

History of concussion: No _____ Yes _____ Details _____

Physician Signature _____ Date _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Fax _____ Email _____

***When a student's condition requires off-campus treatment, his/her return to school is contingent upon approval by the Director of Student Health and/or school physician.**