VCVC Registration Form for Camps & Clinics

Registration and Medical Release Approval

Name of Athlete_____ Age:_____

Grade:_____ School:_____

Medical Condition:_____Past Injuries:_____

Present Medications:_____Allergies:_____

InsuranceCompany:_____Policy#_____

Policy Holder:_____

Insurance Co Address:_____

I verify that my child has been checked by a licensed physician and is physically able to participate in the VCVC clinics. I hereby agree and promise that I will not hold VCVC nor its employees responsible for any authorize the directors of VCVC to act for my child according to their best judgement in an emergency requiring medical attention. I agree to allow my child to be treated by a certified athletic trainer or licensed physician (if necessary) and to assume costs related to such treatment. Also, I authorize the disclosure of medical information to my insurance for the purpose of claim.

Parent or GuardianSignature:_____
Printed Name:_____Date:_____
Street Address:_____City:_____
State:_____ Zip:_____ Home Phone:_____
Cell Phone:_____ Email:_____

Name of Camp or Clinic_____

Date(s) and time(s)_____

Please make checks payable to VCVC or Credit Card payments can be made via PayPal on our website at www.venturacountyvbc.com