



VCVC Registration Form for Camps & Clinics

Registration and Medical Release Approval

Name of Athlete _____ Age: _____

Grade: _____ School: _____

Medical Condition: _____ Past Injuries: _____

Present Medications: _____ Allergies: _____

Insurance Company: _____ 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 Guardian Signature: _____

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