

Chamba Ltd. Co. Medical and Liability Waiver

Date(s): _____

Player's Name: _____

Age: _____

Sex: (Male) (Female)

Please list any allergies, medication or medical conditions: _____

Parent or Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____

E-mail: _____

Emergency Contact and Phone Number if different from above: _____

Physician's Name and Phone Number (Optional): _____

The Parent or Guardian signing below understands that the participant will engage in physical activities with contains risk of physical injury, and assumes the risk and responsibility that may occur during this clinic and releases Chamba Ltd. Co. and its affiliates, schools, directors, coaches, and employees and all staff from any and all liability which may be incurred during this program. I hereby grant permission for my son/daughter to attend a Chamba Ltd. Co. Soccer Clinic and to be treated by a licensed physician or member of the athletic staff for any injury or personal means for any and all medical treatment that may be necessary. I certify that my child is in good health and is able to participate in all camp activities.

Parent's/Guardian's Printed Name

Parent's/Guardian's Signature