



# UNITED SPEED CLINIC



## Builders of Speed, Strength, and a Healthier Soccer Athlete



### Manalapan Soccer Club Wide Clinic

U8+ - Aug 6 - 9, 6:00 - 8:00 pm

\$75.00 per player

U5 - U7 - Aug 6 - 8 6:30 - 8:00

\$65.00 per player

Applications can be mailed to our  
Administrative Offices  
U.S.C.  
Att - Summer Camps  
513 Buttonwood Drive  
Lanoka Harbor, NJ 08734  
609-618-3723

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Camp Location \_\_\_\_\_ Date of Camp \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Program \_\_\_\_\_ Peanuts (U5 - U7). \$65.00 Travel Age (U8 +). \$75.00

Team Age (ex. U-8) \_\_\_\_\_ Team Town \_\_\_\_\_ Team Name (ex. United) \_\_\_\_\_

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

Email Address (*most info will come through e-mail*) \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ Cell/Work Phone # (\_\_\_\_) \_\_\_\_\_

#### Health Information

Name of Personal Physician \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Personal Health Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_  
Group # \_\_\_\_\_

Check all items that apply, past or present, to camper's health history. Explain any "yes" answers.

Asthma	yes no	Diabetes	yes no	High Blood Pressure	yes no
Attention Disorder Deficiency	yes no	Digestion	yes no	Kidney Disease	yes no
Cancer/Leukemia	yes no	Heart Trouble	yes no	Mental Illness	yes no
Convulsions/Seizures	yes no	Hemophilia	yes no	Lungs	yes no
Eyes/Ears/Nose/Throat	yes no			Takes Prescriptions Daily	yes no

Explain \_\_\_\_\_

Allergies: Food, medicines, insects, plants yes no Explain \_\_\_\_\_

Name of Parent or Guardian \_\_\_\_\_

Emergency Contacts: Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone # (\_\_\_\_) \_\_\_\_\_ Cell/Work Phone # (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone # (\_\_\_\_) \_\_\_\_\_ Cell/Work Phone # (\_\_\_\_) \_\_\_\_\_

*In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the physician selected by the adult program coordinator in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.*

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature of Parent/Guardian or Adult \_\_\_\_\_