

SHUTOUT GOALIE ACADEMY

Rich Barnes, Camp Director
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AUTHORIZATION FOR MEDICAL TREATMENT OF MINOR

I hereby certify that _____ is in good health and may participate in all camp/clinic activities. I hereby consent to emergency medical treatment by Rich Barnes, Director of the Shutout Goalie Academy, or trainer to act in my behalf in authorizing emergency medical attention beyond that maintained by the camp/clinic. I hereby waive and release the camp from any and all liability for injuries incurred while at the camp/clinic or arising from travel to and from camp/clinic. The Camp/clinic will not be responsible for medical costs. I also give the Shutout Goalie Academy permission to use, at their discretion, any camp photos.

Camper Name: _____

Insurance Company Name: _____

Parent/Guardian Signature: _____

Insurance ID#: _____

Telephone #: _____

Primary Physician & Phone: _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____

Any additional medical/other concerns that you would like the camp/clinic director to be aware of, please list below: