10 Kingman Street, Suite #14
St. Albans, VT
(802)527-1077

2011 VASL Champions
2009 Highway Safety Lifesaver
2006 Fair Play Award
2003 PDL Northeast Division Champions
2002 Marketing Excellence Award
2010 Bo Vukovic New England Soccer Hall of Fame
2007 United Soccer League Hall of Fame
2005 Franklin County Business Of The Year
2002 PDL Northeast Division Champion
2001 USL Organization Of The Year
2000 USL Progress Of The Year Award

www.voltagesportsclub.com

230 School Street
Bennington, VT
(802)681-7151

Vermont Voltage Residential Overnight Camp LIABILITY/MEDICAL RELEASE FORM One form must be completed for each child that will be attending the camp.

Child's Name _____

Birth Date_____

Grade in School_____

Address _____

City_____ State_____ Zip_____

Phone # _____

Parent/Guardian I, _____ (name) give permission to my above-named son/daughter to attend the Vermont Voltage Soccer Camp. I accept all risks of potential exposure to Covid-19 even with the Covid-19 protection plan in place. If needed for health reasons, I give permission for my child to be evaluated, diagnosed, treated, and /or given medication in accordance with standard medical practice by licensed medical personnel. I relieve Bo Vuckovic and International Soccer Academy, Inc. (dba Vermont Voltage) of all responsibility and consequences that may arise as a result of this treatment. I will not hold Bo Vuckovic or International Soccer Academy, Inc. (dba Vermont Voltage) or the staff liable in the event of injury. Further, I agree to accept any and all financial responsibility as a result of scheduling medical staff. My child agrees to abide by all the rules and regulations stated by Bo Vuckovic and International Soccer Academy, Inc. (dba Vermont Voltage) and the Voltage staff. I understand that Bo Vuckovic and International Soccer Academy, Inc (dba Vermont Voltage) will not be held liable if my child fails to cooperate with regulations.

SIGNATURE OF PARENT/GUARDIAN_____DATE_____

Family Physician _____

Phone # _____

Allergies: Environmental (i.e. Pollen, dust…) _____
Medications_____
Food_____

Current Medications_____

Medical History (be specific) _____

Mental Health Information (be specific) _____

Medical Insurance Provider _____

Insurance No._____

In case of emergency, please contact:

Name_____

Home # _____

Work # _____

Cell # _____

Name_____

Home # _____

Work # _____

Cell # _____