VAST Sports Performance
After-School Program &Summer Camp

Athlete Name: ____________________________________ Age: ____ D.O.B. ___________ Grade:_______

Athlete Name: ____________________________________ Age: ____ D.O.B. ___________ Grade:_______

Athlete Name: ____________________________________ Age: _____D.O.B. ___________ Grade:_______

Parent 1 Name: ____

Parent 1 Phone Number: ____________________________________

Parent 2 Name: ____

Parent 2 Phone Number: _____________________________________

School Attending: ______________________________________

In case of an emergency who do we contact?

Name: ____

Phone Number: _______________________ Relationship to Athlete(s): _________________

Preferred Hospital: ____

Please initial:

__________ I authorize staff to administer Calamine Lotion for temporary relief of pain and itching associated with insects bites, sunburns, poison ivy, and other minor skin irritation.

__________ I authorize Neosporin or Polysporin First Aid Antibiotic Ointment to treat minor cuts, scrapes, and burns.

_________ I authorize **VAST Sports Performance** to pick up my Child(ren) from

______________________________ and drop my Child(ren) to **6026 W Linebaugh Ave. Tampa 33625**.
(Name of School) (Applies to ASP Students Only)

Please list medical conditions and ALL allergies to medications and food (if none, please write "none")

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Parent's Name: ____

Parent's Signature: ____ Date: ______________________