

SESSION (Please Circle) 9AM-12PM Session 1-4PM Session Sessions I II III IV V

MILESTONE TENNIS ACADEMY MEDICAL INFORMATION

PLEASE ATTACH A COPY OF YOUR MEDICAL INSURANCE TO THIS FORM

Camper's Name: _____

Street Address: _____

City: _____

Circle: Male Female Age at Camp: _____ Birth Date: _____ Soc Sec # _____

Parent(s) Name(s): _____

Home Phone: (____) ____ - ____ Business Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____
(Indicate Which Parent) _____ (Indicate Which Parent) _____

Other Emergency Phone: (____) ____ - ____ Email: _____

Family Medical Insurance Information: **Attach copy to form or copy on the back**

Important Medical Information: _____
(Allergies, Medications,
Special Conditions, etc.) _____

Parents' Consent: (Mail to Neil Caniga, Milestone Tennis Academy, 1 Old Ferry Rd. Bristol, RI 02809)

I hereby give consent for my son/daughter, _____ to participate in all activities at the Milestone Tennis Academy. I also declare the above named to be in good health as determined by a doctor at a recent physical. I hereby give the Milestone Tennis Academy permission to render such medical and hospital care as, in their judgment, may seem advisable for my child.

Parent or Guardian Signature: _____