DO NOT MAIL! **BRING TO CHECK-IN on 1st DAY** **DO NOT E-MAIL!**

KORN LEGACY CAMP - 2027

Mitch Korn's Specialized Hockey Camps, Inc. **(DBA Korn Legacy Camp or Korn Camp)**

presents Goaltender and Defenseman programs

Please note the information below from KORN LEGACY CAMP regarding health care:

Please fill out this form COMPLETELY. It is important for the provision of proper medical care. When older participants are seen for minor illnesses or injuries, they are encouraged to inform their parents themselves. However, with younger participants in almost every instance or with older participants with more serious problems, the physician or staff member will try to contact the parents to inform them of the problem and discuss treatment. Occasionally, we are unable to reach parents immediately. The parent's signature on the medical treatment authorization below allows treatment in these circumstances. ***Due to public health issues, DO NOT EXPOSE OTHERS if a participant or family member is ill or displays symptoms.***

Dates attending:_____ Camp Location_____ Program_____

(Please print)

I. PERSONAL INFORMATION

Name:_____
Last First Middle

Date of Birth: ____/____/____ Age:_____ Sex: Male Female

Home Address:_____
No. Street City State Zip Code

Home phone: (____)_____ Parent Cell phone: (____)_____

In case of emergency notify:_____
(name of parent or next of kin) (relationship)

Home phone: (____)_____ Cell phone: (____)_____ Office phone: (____)_____

Alternate Contact Information: (name/relationship)_____

Home phone: (____)_____ Cell phone: (____)_____ Office phone: (____)_____

Family Physician:_____ Phone:_____

II. BACKGROUND (no physician visit is required)

Please provide any pertinent information regarding your child's current health, past medical history, and/or medications taken, that may help us better coach your child and which can assist medical staff should an emergency occur.
(for example: Covid, allergies, allergies to medications, ADD, asthma, head injuries, fractures, epilepsy, learning disorders, surgery, etc.)

_____

_____

_____

_____

player's name: _____

Please list any medications being taken and include dose & frequency.

_____

_____

Have you ever had any of the following: (please check)

_____ Asthma _____ Epilepsy _____ Diabetes _____ Bleeding disorder _____Heart condition _____Covid19

III. INSURANCE INFORMATION (Participant **must** be covered by a health insurance policy.)

Primary Medical Insurance

Company Name:_____

Company Address:_____

_____

Ins. Company phone:_____

Med. Ins. Policy Number:_____

Med. Ins. Group #:_____

Name of person insured:_____

DOB of insured:_____

SS# of insured: _____

Employer of insured:_____

Dental Insurance

Company Name:_____

Company Address:_____

_____

Ins. Company phone:_____

Dental Ins. Policy Number:_____

Dental Ins. Group #:_____

Name of person insured:_____

DOB of insured:_____

SS# of insured:_____

Employer of insured:_____

IV. MEDICAL TREATMENT AUTHORIZATION AND LIABILITY RELEASE

I, the undersigned acknowledge that I am the parent or guardian of_____ and do hereby grant my permission for my hockey player to attend a Mitch Korn's Specialized Hockey Camps, Inc.'s Program (DBA Korn Legacy Camp or Korn Camp), and to actively and fully participate in all activities thereof. In the event of an injury or illness during these activities, my signature indicates that I agree to allow medical treatment even if I cannot be contacted, and authorize Mitch Korn's Specialized Hockey Camps, Inc. and/or the local hospital to provide the needed medical treatment they deem necessary. I hereby release Mitch Korn, all members of the program's staff, the host ice facility and its staff, the local hospital and their doctors, agents, employees, and representatives, and all officers of Mitch Korn's Specialized Hockey Camps, Inc., (DBA Korn Legacy Camp or Korn Camp) from any and all claims and liability arising in any way out of its exercise of this authority. I understand and agree that all bills for any medical/dental care and treatment will be forwarded to me, or my insurance company, and that it will be my responsibility to see that such bills are paid. I further acknowledge, understand, and agree that in participating in this activity there is a possibility of illness or injury and that I, as parent or guardian of my hockey player, am assuming the risk of such illness or injury by his/her participation and release Mitch Korn, the program's staff, the Host Ice Rink and it's staff, and all affiliated with or participating in the Mitch Korn's Specialized Hockey Camps, Inc., (DBA Korn Legacy Camp or Korn Camp) program from all liability, claims, obligations or responsibility for personal property losses, accidents, illnesses or injuries of any kind. I understand the inherent risks of being near others and of the training process for being a hockey player and recognize that the program is strenuous. I have received a copy of the schedule and understand the activities. I understand that full, legal equipment is to be worn properly at all times on ice or on the bench. I know that this camp is NOT affiliated with the Nashville Predators. I further authorize the program staff to administer non-prescription analgesics for minor medical problems such as headaches, etc. unless I have requested otherwise.

_____ _____

parent / guardian signature and relationship **hockey player's signature**

_____ _____

Date **Date**