SPORTS CAMPS

UNIVERSAL ATHLETIC CLUB

2019 SESSION REGISTRATION

Cost $99 per week, per camper.

$49 when enrolled in full time Camp Universal the same week

Payment in full due at time of registration.

Space is limited. First come, first serve.

SELECT YOUR CAMP(S)

☐	**Football**	**June 17-21**	**5pm-8pm**
☐	**Tennis**	**July 8-12**	**12pm-3pm**
☐	**Soccer**	**July 15-19**	**9am-12pm**
☐	**Sports Performance**	**July 22-26**	**9am-12pm**
☐	**Basketball**	**July 29-Aug. 2**	**9am-12pm**
☐	**Sports Performance**	**August 12-16**	**9am-12pm**

Please Complete One Form Per Camper

Camper Last Name: _____

Camper First Name: _____

D.O.B: _____

Universal Member: Yes No

Parent Name (Print): _____

Address: _____

Email: _____

Home Phone: _____

Cell Phone: _____

UNIVERSAL ATHLETIC CLUB

Internal Use:

Method of Payment

☐ Check # _____

☐ Credit Card

☐ Cash

Paid $: _____

Date: _____

2323 Oregon Pike · Lancaster · 717-569-5396

www.UniversalAthleticClub.com

MODEL RELEASE

RELEASE TO USE PICTURES

In consideration of my participation in programs at Universal Athletic Club, Inc. ("Universal"), I hereby give Universal, its legal representatives and assigns and those acting with its permission, the right to copyright and/or use, reuse and/or publish and republish pictures of me in any advertising, promotion or public relations involving Universal and its facilities. Due to printing, photographing and reproduction techniques, my image may be distorted in character or form and I do not object to this.

I hereby waive any right to inspect or approve the finished picture, advertising copy or other matter that may be used in conjunction with pictures of me.

I hereby release, discharge and agree to save Universal, its representatives, assigns, employees or any person acting with its permission, from and against any liability as a result of any distortion, alteration or use in composite form of my picture.

I have read this Release and I fully understand the contents of it.

Signature: _____

For a Minor:

I hereby certify that I am the parent and/or guardian of _____ a minor under the age of twenty one years. In consideration of value received, the receipt of which is hereby acknowledged, I hereby consent to use by Universal (as set forth above) of any pictures of such minor which have been or are taken.

Guardian's signature : _____

Address: _____

_____

Date: _____

2323 Oregon Pike, Lancaster, PA 17601
717-569-5396
www.UniversalAthleticClub.com

CHILD HEALTH APPRAISAL

CHILD DAY CARE CENTERS– GROUP DAY CARE HOMES -FAMILY DAY CARE HOMES

DATE OF EXAM

CHILD'S NAME : LAST, FIRST, MIDDLE	BIRTHDATE
CHILD ADDRESS	TELEPHONE NUMBER

1. REVIEW OF HEALTH HISTORY	2. MEDICAL INFO. PERTINENT TO DIAG. AND TREATMENT IN CASE OF EMERGENCY
3. SPECIAL INSTRUCTIONS TO PROVIDER REGARDING ANY MEDICATION REQUIRED DURING DAY CARE HOURS	4. RECOMMENDED MODIFICATIONS OR LIMITATIONS OF CHILD'S ACTIVITIES OR DIET (ALLERGIES, ETC.)

5. VISION (ACUITY) ☐ NORMAL ☐ ABNOR-	6. HEARING (AUDITORY) SUBJECTIVE SCREENING DATE _____ AUDITORY DATE _____	7. GROWTH MEASUREMENT Ht._____' _____ PERCENTILE WT. _____ LBS. _____ PERCENTILE CIRC. _____-___

10. DENTAL SCREENING	YES	NO
CARIES		
MISSING PERMANENT TEETH		
ORAL INFECTION		
PROTRUSIONS		

9. MEDICAL					
	NORMAL	ABNOR-		NORMAL	ABNOR-
EARS/NOSE			ABDOMEN		
EYES			GENITALIA/ BREASTS		
MOUTH/			EXTREMITIES/JOINTS		
LUNGS			SPINE		
CARDIOVASCULAR			SKIN/ LYMPH		

10. HGB
HGB ☐ NORMAL ☐ ABNORMAL

GM OR HTC ☐ NORMAL ☐ ABNORMAL

%

11. BLOOD PRESSURE /

☐ NORMAL ☐ ABNORMAL

12. DEVELOPMENTAL APPRAISAL IS CHILD PROGRESSING NORMALLY WITH AGE OR GROUP? ☐ YES ☐ NO	DENVER DEVELOPMENTAL ☐ YES ☐ NO

13. IMMUNIZATIONS

DTP: DIPHTHERIA-TETANUS-PARESIS	DATE	TRIVALENT ORAL POLIO VACCINE	DATE	OTHER:	DATE
1ST 12 MONTHS		1ST 12 MONTHS		MEASLES (15 MONTHS OR OLDER)	
2ND 14 MONTHS		2ND 14 MONTHS		MUMPS (15 MONTHS OR OLDER)	
3RD 18 MONTHS		3RD 18 MONTHS		RUBELLA (15 MONTHS OR OLDER)	
BOOSTER		4TH (4-8 YEARS)		HIS HOMOPHILES (18 MONTHS)	
BOOSTER		URINALYSIS		TUBERCULOSIS TEST	

14. RECOMMENDED FURTHER MEDICAL TESTS OR EXAMINATION ON THE FOLLOWING:

☐ VISION ☐ GROWTH ☐ HBG ☐ HEAD CIRCUMFERENCE ☐ HEARING ☐ DENTAL ☐ BLOOD PRESSURE

☐ MEDICAL (SPECIFY)

☐ DEVELOPMENTAL PROGRESS (SPECIFY)

☐ IMMUNIZATION (SPECIFY)

PRINTED NAME OF PHYSICIAN	TELEPHONE NO.	
PHYSICIAN'S ADDRESS		PHYSICIAN'S SIGNATURE DATE