Camp Dates:
June 10th – July 19th
Monday, Wednesday, Friday
12:30 -2:00 pm

Program is $300 payable by check or credit card to CTPO.

central texas
PEDIATRIC ORTHOPEDICS

Please select a location:

Austin:
Soccer Zone
9501 Manchaca Rd.
Austin, TX 78748

Cedar Park:
Mad Training
715 Discovery Blvd.
Suite 506
Cedar Park, TX 78613

2019 ACL Injury Prevention Summer Program Enrollment Form

Last Day to Register: June 3, 2019

Participant Information:

Child's Name _____ **Date of Birth** ____/____/____

Home Address _____ **City / State** _____ **Zip** _____

School Attending _____ **Home Telephone** _____

Mother's Name _____ **Work** _____ **Cell** _____

Father's Name _____ **Work** _____ **Cell** _____

Family Email Address _____ **T-Shirt Size:** ☐ **Small** ☐ **Medium** ☐ **Large**

Medical Health Insurance Information:

Physician Name _____ **Physician Phone** _____

Physician Address _____

Dentist Name _____ **Dentist Phone** _____

Dentist Address _____ **Member Svcs** _____

Health Ins Plan _____ **Telephone** _____

Group # _____ **Policy #** _____

Parent Medical Treatment Authorization

I/We, the parents of the above named child who is enrolling in the ACL Injury Prevention Summer program conducted by Central Texas Pediatric Orthopedics & Scoliosis Surgery (CTPO), hereby give my/our approval to participate in any and all activities conducted as part of the program. Other than those listed below, my/our child has no physical or mental limitations or impairments, is currently taking no medication, and has no allergies which I/we feel is important and should be disclosed to CTPO.

_____

(if none, indicate "none")

I/We know that participation in sports programs at CTPO, and in general, may result in serious injuries and with knowledge of this do hereby waive, release, absolve, indemnify and agree to hold harmless CTPO and its Board of Directors and staff, sponsors, supervisors, and participants for any claim arising out of any injury to my/our child whether the result of negligence or for any other cause, except to the extent and in the amount covered by accident liability insurance.

In the event of injury or illness to my child, _____ (name of child), I/we hereby grant authority to a licensed medical doctor to render such medical treatment as said doctor deems necessary under the circumstances. (MUST BE SIGNED BY BOTH PARENTS. IF NOT, STATE REASON ON VACANT SIGNATURE LINE.)

_____ Mother's Permission Granted

_____ Father's Permission Granted