BODY ZONE™
Sports & Wellness Complex

3103 Paper Mill Road • Wyomissing PA 19610
610-376-2100 • FAX 610-376-4131 • BODYZONESPORTS.COM

SCHOOL'S OUT DAY CAMP MEDICAL FORM

Camper Information

Email Address (REQUIRED) _____

First Name_____ Last Name _____

Home Address_____ City _____ State _____ Zip _____

Home Phone _____ Daytime Phone _____

Date of Birth (MM/DD/YYYY) _____ Age _____ Circle: Male Female

Emergency Contact Name _____ Relation _____

Home Phone _____ Work Phone _____ Cell Phone_____

If participant is under age 18, this information is required:

Parent(s) _____ _____
NAME NAME

_____ _____
HOME PHONE WORK PHONE HOME PHONE WORK PHONE

PLEASE COMPLETE MEDICAL INFORMATION ON REVERSE SIDE OF THIS FORM

ASSUMPTION OF RISK AND WAIVER

The use of fitness equipment, participating in fitness programs, and playing contact sports such as ice hockey, soccer, field hockey, lacrosse, basketball, and others are inherently dangerous. The undersigned, on behalf of the undersigned and the undersigned's child (collectively "Participant") hereby: (1) assume the risk of personal injury, property damage, or other loss (collectively "Injuries") to the Participant arising from or related to the activities conducted and services provided at Body Zone Sports and Wellness Complex; (2) unconditionally waive, release, and discharge WRC Sports and Fitness, LP and its agents, staff members, officers, directors, partners, members (collectively the "Released Parties") from all liability, claims, or responsibility for injuries to Participant; (3) grant permission for Participant to participate in activities at Body Zone Sports and Wellness Complex; (4) unconditionally release the Released Parties from injury arising from any good faith acts or omissions in emergency situations; (5) give permission to the staff to evaluate and treat my child, while participating in activities at Body Zone and (6) fully assume the risks, both known and unknown, of exposure, illness or death related to infectious diseases, including but not limited to MRSA, influenza, and COVID-19, even if arising from the negligence of the released parties or other participants.

I agree that you may photograph and/or videotape me or my child during my activities and that you retain the right to use these visual images in future literature for Body Zone Sports and Wellness Complex without compensation to me or my child. I further agree that you may use my name, my child's name, or any testimonials made by us without limitation in advertising and promoting Body Zone Sports and Wellness Complex.

I represent that I am over the age of 18 or a parent/guardian of the minor named above, and agree that the grant and release contained therein binds me and the minor of all of its terms.

Parent/Guardian Signature: _____ Date: _____

(PARENT/GUARDIAN MUST BE 18 YEARS OF AGE)

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Physician Name _____ Phone _____

Will your child be taking medication (circle one): YES NO If yes, what type?_____
Please send all medication in a clear Ziploc bag with a label and specific instructions.

Does your child have any allergies (circle one): YES NO

TYPE:	EXPLAIN SYMPTOMS AND SEVERITY:
☐ Bee sting	_____
☐ Peanut/Nut	_____
☐ Drugs	_____
☐ Food	_____
☐ Other	_____

Does your child have chronic or recurring illness (circle one): YES NO

TYPE	PLEASE EXPLAIN IN DETAIL:
☐ Asthma	_____
☐ Diabetes	_____
☐ Seizures	_____
☐ Cardiac	_____
☐ Other	_____

Are there any limitations/issues we should be aware of (circle one): YES NO

If yes, please explain: _____

_____

PICKUP CONSENT

I give permission for the following persons to pick up my child(ren) from camp. (PHOTO I.D. REQUIRED)

_____ _____
NAME **PHONE**

_____ _____
NAME **PHONE**