Parent Information Form

Date: _______/ _______/ _______

Please Print Clearly

Fathers Name:___________________________ ___________________________
First Last

Mothers Name: ___________________________ ___________________________
First Last

Student Home Address:

____

City___________________________ State:_____________ Zip:________________

Fathers Contact Number ( ) _______-____________ Email Address: ______________________

Mothers Contact Number ( ) _______-____________ Email Address: ______________________

Parent Certification – I am supportive of my child's participation in the Orlando Minority Youth Golf Program. I give my permission for the below named youth to participate in rehearsals and performances as outlined below.

____
Parent or Guardian Signature

_____/_____/____
Date

Release of Claims: I hereby release the Orlando Minority Youth Golf Association, their agents, and their sponsors from the claims of any injuries to the above named youth which might occur during participation in any of the following golf activities.

____
Parent or Guardian Signature

_____/_____/____
Date

Authorization for Medical Treatment: I authorize the sponsors of this activity, as my agent, to consent to any necessary medical or dental treatment deemed necessary for the above named youth while participating in any of the following golf activities.

____
Parent or Guardian Signature

_____/_____/____
Date

Who referred your child/children to the Howard Golf Camp?

____

Method of Payment

Check	Cash	Amount	Total Amount Paid	Balance

Registration Form

2024

Registration Fee

$540.00 Each Student

1.

Last Name	First Name	Initial	Birth Date	Age

Male or Female	Current School Attending:	Grade:	School Phone #

List Physical Limitations: ____

*Physician'sName:_______________________________________ Phone:(______)_________-___________

Medical Record on File?: YES or NO (If no please bring your medical record or physical to the first day of camp).

2.

Last Name	First Name	Initial	Birth Date	Age

Male or Female	Current School Attending:	Grade:	School Phone #

List Physical Limitations: ____

*Physician'sName:_______________________________________ Phone:(______)_________-___________

Medical Record on File?: YES or NO (If no please bring your medical record or physical to the first day of camp).

3.

Last Name	First Name	Initial	Birth Date	Age

Male or Female	Current School Attending:	Grade:	School Phone #

List Physical Limitations: ____

*Physician'sName:_______________________________________ Phone:(______)_________-___________

Medical Record on File?: YES or NO (If no please bring your medical record or physical to the first day of camp).

4.

Last Name	First Name	Initial	Birth Date	Age

Male or Female	Current School Attending:	Grade:	School Phone #

List Physical Limitations: ____

*Physician'sName:_______________________________________ Phone:(______)_________-___________

Medical Record on File?: YES or NO (If no please bring your medical record or physical to the first day of camp).

2024 Parent Consent Form

Parent Certification – I am supportive of my child's participation in the Howard Golf Camp. I give my permission for the below named youth to participate in rehearsals and performances as outlined below.

______________________________ ____/_____/____ _______
Youth to Participate Date of Birth Age

______________________________ ____/_____/____ _______
Youth to Participate Date of Birth Age

______________________________ ____/_____/____ _______
Youth to Participate Date of Birth Age

______________________________ ____/_____/____ _______
Youth to Participate Date of Birth Age

______________________________ ____/_____/____ ____________________________
Parent or Guardian's Consent Date Contact Number

Release of Claims: I hereby release the Howard Golf Camp, their agents, and their sponsors from the claims of any injuries to the above named youth/youths which might occur during participation in any of the following golf activities.

_______________________________ ______/_____/____

Parent or Guardian Signature *Date*

Authorization for Medical Treatment: I authorize the sponsors of this activity, as my agent, to consent to any necessary medical or dental treatment deemed necessary for the above named youth while participating in any of the following golf activities.

_______________________________ ______/_____/____
ParentorGuardianSignature Date

Howard Golf Camp **STUDENT LIABILITY FORM 2024**

I, ____

I, ____

I, ____

I, ____

Do hereby release Samuel Puryear and the Howard Golf Camp from any liability in the event of injury should it occur with my child or children during the course of Lecture, Practice, Play, or Golf Outings of any kind.

I understand that safety measures will be taken to avoid such occurrences, as accidents, bodily or mental harm do sometimes occur. Further, I give the right to Samuel Puryear and the Howard Golf Camp to take photos, videos, and other diagnostic aides that may be used in the teaching of my child. These photos, videos, and other diagnostic aides are considered to be the property of Samuel Puryear and the Howard Golf Camp and may be used for the good of the child and/or the organization at the discretion of Samuel Puryear. This serves as release of liability, release of photo, visuals, or auditory processes involved in the teaching of the youth, past, present, or future.

____
Parent or Guardian

Date ________ /_________ /________

STATE OF ________________
COUNTY OF ________________

Sworn to (or affirmed) and subscribed before me this ________day of ______________, 2024

by____.

Identification Produced & ID Number (if applicable) ____

____
Name of Notary Public

My Commission Expires:
____

STUDENT AGREEMENT FORM
Howard Golf Camp 2024

1) I agree to attend golf classes and practice sessions.

2) I agree to do my best to become the best golfer that I can.

3) I agree to conduct myself at all times in a manner befitting me as a member of the Howard Golf Camp.

4) I agree to respect my parents at all times. I will not talk in a bad way to them.

5) I agree to respect my fellow man and his property.

6) I agree to maintain positive self-control at all times.

7) I agree to use golf as my fun, rather than drugs.

8) I agree to become the best student that I can be.

9) I agree to grow up and become the best citizen I can be.

10) I agree to choose golf rather than crime.

THESE 10 STATEMENTS I AGREE TO OF MY OWN FREE WILL.
Each Youth Please Sign

____/____/____ ________________________________

SIGNATURE of Student DATE

____/____/____ ________________________________

SIGNATURE of Student DATE

____/____/____ ________________________________

SIGNATURE of Student DATE

____/____/____ ________________________________

SIGNATURE of Student DATE

MEDICAL INFORMATION SHEET

Name: ____

Mother's Name: ___________________________ Father's Name: ____________________________

Telephone Numbers: Mother______________________ Father________________________________

Alternate Emergency Contacts (If parents are not available)

Name:___________________________________ Telephone:(____)_________________

Name:___________________________________ Telephone:(____)_________________

Doctor'sName:_____________________________ Telephone:(____)_________________

Dentist'sName:_____________________________ Telephone:(____)_________________

Please circle the appropriate response and provide details below if you answer "Yes" to any of the questions.

Yes•No Faintingepisodesduringexercise Yes•NoEpileptic

Yes•No Troublebreathingduringexercise Yes•NoAsthma

Yes•NoDiabetic–Type1____Type2____ Yes•NoHeartCondition

Yes•NoMedication Yes•NoAllergies

Yes • No Wears a Medical Information Bracelet/Necklace For what purpose?

Please give details if you answered "Yes" to any of the above.

Medications: ____

Allergies: ____

Medical Conditions: ____

Any information not covered above: ____

I understand that it is my responsibility to keep the Howard Golf Camp advised of any change in the above information as soon as possible. Intheeventofamedicalemergencyandthatnoonecanbecontacted,theHowardGolfCampwillarrangetotakemy child to a physician or the hospital if deemed necessary.

I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child.

I also authorize release of information to appropriate people (coach, physician) as deemed necessary.

Date:____________ SignatureofParentorGuardian:__________________________________