2019 SUFFOLK COUNTY FOOTBALL SHOWCASE

Registration Form: Mail check in the amount of $130 payable to SCFCA
Or pay $150 day of event - 6 or more players from same HS $100 each player
SCFCA Long Island Football Showcase
Box 406 Farmingville NY 11738
www.liblitz.com

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

E Mail: _____ **DOB:** ___/___/___ **Age:** _____

Home Phone: _____ **Mobile:** _____

High School: _____ **Graduation Year:** _____

SAT Score: Math_____ **Reading** _____ **GPA:** _____ **Height:** ____ **Weight:** ____

Offensive Position: _____ **Defensive Position:** _____

Special Teams Position: _____ **Athletic Achievements:** _____

Parental Release

I authorize the staff of the Long Island Showcase to use their best judgment in allowing my child to receive emergency/medical or surgical treatment if necessary. I understand that every effort will be made to contact me prior to such action. Please be advised that it is imperative that your child be in good health arriving at the camp/showcase. The duties of camp personnel cannot include providing medical care for campers arriving at the camp/showcase with pre-existing condition.

I hereby: 1. Certify that to the best of my knowledge, the medical information is complete and correct. 2. Agree to assume all risks of personal injury rising from participation in this camp, understanding that sport does involve the potential for injury. 3. Agree not to bring suit against SCFCA Long Island Football High School Showcase case for any injury sustained. 4. Agree not to hold the staff responsible for any injury sustained. 5. Agree to allow the camp director to use sound judgment in obtaining necessary medical care, at the expense of the parent. 6. Agree to accept any decision made by the camp/showcase in terminating attendance due to unacceptable behavior.

Medical Form

Childs Name: _____ **Parent/Guardian:** _____

Address: _____ **Home Phone:** _____

An alternative contact person that can be contacted in case of an emergency is:

Name: _____ **Phone:** _____

Family Physician: _____ **Phone:** _____

Please list any allergies, illnesses or injuries in the past year or if you take medications on a daily basis: _____

_____

Signed: (Parent/Guardian) _____

Absolutely No Refunds After Friday May 17, 2019