

# 2022 SUFFOLK COUNTY FOOTBALL SHOWCASE

**Registration Form:** Mail check in the amount of \$60 payable to SCFCA or pay \$80 day of event  
SCFCA – Suffolk County Football Showcase  
169 Park Avenue Babylon NY, 11702  
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 Thursday May 19th**