

REGISTRATION FORM

Name: _____ Grade Next Fall: _____ Club Team: _____

Address: _____ School: _____

City: _____ State: _____ Zip: _____ D.O.B.: _____

Parent Cell: () _____ Emergency Phone: () _____

Email: _____ Parents Email: _____

Adult T-shirt size: XS S M L XL XXL (circle one) Height: _____

WHICH CAMPS ARE YOU ATTENDING

Position: S M OH RS Libero (circle one)

- checkbox All Skills Camp Grades 4-7 June 2-3 9:00am - 12:00pm (COST IS \$100)**
checkbox All Skills Camp Grades 8-12 June 2-3 1:00pm - 4:00pm (COST IS \$100)**
checkbox Varsity Position Camp for Setters July 11-12 9:00am - 12:00pm (COST IS \$150)**
checkbox Varsity Position Camp for Hitters July 11-12 1:00pm - 4:00pm (COST IS \$150)**
checkbox Varsity Defensive Camp July 11-12 6:00pm - 9:00pm (COST IS \$150)**

** Remember there is a multi-camp discount for attending more than one position camp!!

MEDICAL RELEASE AND WAIVER

I (we), the undersigned parent(s)/guardian(s) of said participant, fully understand that there are risks involved in my (our) child's participation in the said camp. I (we) represent that (my) our child voluntarily desires to participate in activity; and that I (we) am (are) duly aware of the risks and hazards that may arise through participation in activity. In consideration for my (our) child's participation in said camp, the undersigned hereby voluntarily assumes all risks of accident or damage to person or property and risks of liability. The undersigned does further agree to indemnify and hold harmless Belle Volleyball Camps, Angelo State University and its regents, administrators, employees or agents from any and all claims or demands for loss, cost, injury, or damage whatsoever arising from negligence, especially from injury resulting from my (our) child's improper use of equipment, technique, or failure to follow safety rules and instructions. The undersigned, by signing this release, hereby certifies that the undersigned has read and fully understands the conditions herein provided and that he/she signs this agreement voluntarily and without reliance upon any promise or representation which is not contained in this agreement.

We (I) give authorization to the athletic training staff or designated entity to evaluate our (my) child and treat any injuries that occur during said activity. This includes immediate first and treatment, referral to hospital or physician consultation, and/or emergency services. We (I) hereby grant the athletic training staff or designated entity to secure medical services that are in the best interest of our (my) child.

Date: _____

Camper's Name: _____

Printed Parents Name: _____

Parent's Signature: _____

Please make all checks out to Belle Volleyball

Mail Check and Registration Form to: Belle Volleyball - Angelo State University Attn: Chuck Waddington ASU Station # 10899 San Angelo, TX 76909-0899

Phone: 325-486-6068 Fax: 325-942-2277 Email: cwaddington@angelo.edu