

Team Roster

TEAM NAME: _____ Varsity or JV

CHAPERONE'S NAME: _____

CHAPERONE'S PHONE: _____

CHAPERONE'S EMAIL: _____

Player List:

T-shirt Size

(Adult S, M, L, XL)

(1)	_____	_____
(2)	_____	_____
(3)	_____	_____
(4)	_____	_____
(5)	_____	_____
(6)	_____	_____
(7)	_____	_____
** (8)	_____	_____
(9)	_____	_____
(10)	_____	_____
(11)	_____	_____
(12)	_____	_____

****You need a minimum of 8 players per team. Maximum of 12**

Please mail me a copy of this completed roster page to the following address:

Attn: Chuck Waddington
Angelo State University
ASU Station #10899
San Angelo, TX 76909

ASU Volleyball Team Camp Medical Release and Participation 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 Parent's Name: _____

Parent's Signature: _____

Each participating athlete must have a copy of this participation waiver signed by his/her parent or guardian in order to participate in our Team Competition Camp. Please make copies of this form for each of the athletes listed on the team roster. In addition to this form, there is a \$20 participation fee for each athlete on the roster. The form and fee are due at check-in on the first day of camp.