

Rocky Mountain Soccer Camps, Inc.

TEAM CAMP PLAYER APPLICATION

(Please fill out ENTIRE Form)

PLAYER NAME _____ AGE (As of Camp Date) _____ M/F _____ BIRTHDAY ____/____/____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
E-MAIL ADDRESS _____

TEAM _____
COACH _____
TEAM CAMP DATES _____
LOCATION ELEVATION TRAINING CENTER – VICTOR, CO

In consideration of being permitted to take part in the activity set forth herein, I expressly agree as follows: I hereby acknowledge that the activity set forth herein contains dangers and risks and may result in injury to the participant. I hereby assume all risks of personal injury or death and property damage from any causes whatsoever arising while my child is participating in such activity. My child is in good health and is physically able to participate in said activity. I hereby agree to unconditionally waive and release the ROCKY MOUNTAIN SOCCER CAMPS, INC., their officers, employees, agents, servants and all representatives and sponsors from any injury that my child may sustain or any damage that may be caused to my child's property in connection with any ROCKY MOUNTAIN SOCCER CAMPS, INC. activity. I also agree to indemnify and forever hold harmless the ROCKY MOUNTAIN SOCCER CAMPS, INC. for any claims arising out of injury or death to my child, other than gross negligence or willful misconduct of the ROCKY MOUNTAIN SOCCER CAMPS, INC. I also authorize and consent to any emergency X-ray examination, medical diagnosis or treatment and hospital care and on the advice of any physician licensed to practice in the state of Colorado or in the United States of America.

I, furthermore, hereby give my permission to the ROCKY MOUNTAIN SOCCER CAMPS, INC. to use my child's name, likeness, image and photograph for any camp promotional or advertising purposes including, but not limited to, brochures, flyers, internet web sites, and videos.

Parent or guardian signed will be contacted and will be responsible for the health insurance of their child.

Parent/Guardian Signature _____

Please indicate any known ALLERGIES, DISABILITIES, or MEDICAL PROBLEMS: _____
INSURANCE COMPANY _____ PHONE _____ POLICY or GROUP NUMBER _____

PARENT/GUARDIAN _____ RELATIONSHIP _____ H) PHONE _____ M) PHONE _____
EMERGENCY CONTACT _____ RELATIONSHIP _____ H) PHONE _____ M) PHONE _____

Please Return this Completed FORM to your COACH or TEAM MANAGER

(For Official Use Only)				
CHECK #1	DATE RECEIVED	NAME	AMOUNT \$	BALANCE \$
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