



2017 Summer Camp  
July 14 - 16, 2017  
Resident Camper: \$225  
Commuter Camper: \$200  
Send check to  
Payable to: Truman Women's  
Soccer  
Attn: Mike Cannon  
100 E Normal  
Kirksville, MO 63501

Participant First Name: \_\_\_\_\_

Participant Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email 1: \_\_\_\_\_

Email 2: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

T-Shirt Size: \_\_\_\_\_

Roommate Preference: \_\_\_\_\_

Position: \_\_\_\_\_ Grade Next Fall: \_\_\_\_\_ School: \_\_\_\_\_

Height: \_\_\_\_\_

Parents Name/s: \_\_\_\_\_

Parents Phone: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

Health Insurance Company Phone: \_\_\_\_\_

Group Policy #: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Dominant Foot: \_\_\_\_\_

Club Team: \_\_\_\_\_

How did you hear about Camp?: \_\_\_\_\_

Camp Waiver:

By signing below, I understand that I am authorizing the participant named above to attend the Truman State University Soccer Camp and to participate in that camp actively and fully. I understand that this activity carries with it the potential for personal injury, and I accept this risk on behalf of my child. On behalf of my child and myself, I hereby release the University, its officers, and employees, including the Athletic Department and its staff, from any liability or claims for damages arising from personal injury sustained by my child during this activity. My child and I understand the nature of the risks of injury involved in this activity and I assume all responsibility for any injuries incurred during participation at this camp. I know of no mental or physical problems that might adversely affect my child's ability to participate in this camp.

I understand further that I will be responsible for any expenses incurred on behalf of the participant in connection with any first aid, medication, medical treatment, or surgery that may be deemed medically necessary on account of any injuries sustained in this activity. I hereby authorize the certified athletic trainer to secure any needed medical treatment for this participant and to execute whatever documents and releases are necessary for securing such medical treatment in the event that I am not immediately available to do so. I further state that this participant is covered under a policy of medical/health insurance with: I understand that the University will carry no health insurance coverage on the participant during this camp activity, and I am fully responsible for any and all medical expenses incurred on behalf of the participant.

As a participant in the Truman State University Soccer Camp, I agree to comply with all of the rules, regulations, and directives of the University coaching staff, and I will treat all coaching staff and other camp participants with respect, courtesy, and good will. I have read the above Insurance Statement/Release of Liability and agree that it is correct to the best of my knowledge.

I agree to the above Waiver Agreement: \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_