

2017 Sports Performance Volleyball Marshfield All Skills Camp

Name: _____ Grade (fall of 2017): _____
Address: _____ Home Phone: _____
Cell Phone: _____ T-shirt Size: _____

Community Team Camp

Held in your own community these camps are an excellent way of combining elite training with a low cost, affordable camp experience.

Sports Performance Staff

Our staff consists of specialists in training Youth, Jr. High, High School and Elite level athletes. Our commitment to you is that we will give our best to make sure that you feel the experience, while maybe demanding, was well worth the time, effort and expense.

Rick and Cheryl Butler
Program Directors

High School All Skills Camp

Date: July 31st – August 4th, 2017
Time: 8:00 am Setter Training
9:00 – 12:00 High School Training
12:00 – 1:30 Lunch Break
1:30 – 3:30 High School Training
Cost: \$180 (includes camp t-shirt)

Please make checks payable to Marshfield High School Volleyball

Send to Tammie Montiel

2640 N 15th Ct. Coos Bay, OR 97420

Please email or phone if there are any questions.

tammie@coos-bay.k12.or.us

541-404-6401

WAIVER, RELEASE AND INSURANCE INFORMATION

AS CUSTODIAL PARENT OR COURT-APPOINTED GUARDIAN OF _____ ("CHILD"), I DO FOR BOTH OF CHILD'S PARENTS, FOR CHILD AND CHILD'S HEIRS AND SUCCESSORS, RELEASE GLV, INC. AND ANY OF ITS AGENTS, EMPLOYEES OR REPRESENTATIVES (ALL OF THE FOREGOING COLLECTIVELY "GLV, INC.") FROM ALL CLAIMS ARISING OUT OF OR CONNECTED WITH CHILD'S PARTICIPATION IN ANY GLV, INC. PROGRAM. I PROVIDE THIS RELEASE BECAUSE I AM MINDFUL THAT ATHLETICS, PHYSICAL TRAINING AND COMPETITION CAN BE A DANGEROUS UNDERTAKING REGARDLESS OF HOW CAREFUL OR PRUDENT ANY PERSON, FIRM OR FACILITY MIGHT BE. Further, I give permission to GLV, INC. to treat Child or arrange for medical care or treatment for Child in any situation deemed reasonably necessary by GLV, INC. if circumstances permit. GLV, INC. shall attempt to communicate first via telephone with the following emergency contacts for child:

Primary Emergency Contact: _____

Secondary Emergency Contact: _____

(Name and Relationship) (telephone number)

(Name and Relationship) (telephone number)

In the event neither emergency contact can be reached or if the urgency of the situation requires immediate attention without prior telephone contact, GLV, INC. may arrange for medical treatment for the Child at the expense of the parent or guardian signing this form. Health Insurance, PPO information for Child is as follows:

Insurance Policy Number: _____

Address: _____ City: _____ State: _____ Zip: _____ Telephone: _____

In order to seek appropriate medical care of treatment of Child, please disclose the following:

Allergies: _____ (Please specify, enter "None" or leave blank)
Heart disease or other: _____ (Please specify, enter "None" or leave blank)

Any other conditions, symptom or disability which would or might affect medical care or treatment or participation in the GLV, INC. program: (Please specify, enter "None" or leave blank) _____

Date: _____ Signature (Parent or Court Appointed Guardian): _____