

# 2019 REDHAWKS FOOTBALL CAMP REGISTRATION



## Camper Information *(required)*

Last Name	First Name	Middle Initial
Street	City	State
Zip Code	Birth Date: ____/____/____	Current Age: ____
Email: _____		

*(All camp info & confirmations will be sent via email)*

Please check next to the camp(s) you will be attending:

Individual Camp (June 16)     
  Individual Camp (July 14)     
  Specialists Camp (July 13)  
 Team Camp (One Day)     
  Team Camp (2 Days Commute)     
  Team Camp (2 Days Resident)

## Parent/Guardian Information *(required)*

Name(s)	Relationship
Phone: Primary (____) _____	Email: _____
Secondary (____) _____	

In case of an emergency and parent cannot be reached at above numbers, contact:

Name	Relationship
Phone: Primary (____) _____	Secondary (____) _____

## Medical Information *(required)*

In the event of an accident or special health needs, it will be necessary for us to have the requested information. Please make certain that you have provided thorough and accurate medical information.

Medications taken for current medical conditions (asthma, allergies, etc.)	Medications taken occasionally (headaches, etc.)
Do you plan to bring these or any other medications to camp with you?	YES _____ NO _____

Insurance Company	Policy Number	Group Number
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Known allergies or other conditions

### Release of Photographs, Video, Audio, and Related Media Formats: *(Permission Granted without Restriction)*

The University and its affiliates may use my child's image with or without attribution to his/her name.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Printed Name \_\_\_\_\_

### Release of Liability:

The signature provided confirms I have read and fully completed the Medical information, the University Camp Rules & Expectations and the release of Liability and freely and voluntarily agree to the terms and conditions of this release in order to participate in any and all camp activities unless specified above. I acknowledge the information I have given is correct to the best of my knowledge. Furthermore, I give permission for the Southeast Missouri State University staff to provide and authorize any medical treatment if necessary.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Printed Name \_\_\_\_\_