



SC VISTULA GARFIELD REGISTRATION FORM SOCCER CAMP

First Name: _____ Last Name: _____

Date of Birth: ____/____/____ Parent/Guardian Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Home Phone: _(____)____-____ Cell Phone: _(____)____-____ Text: ____ Email: ____

Emergency Contact Name: _____ Phone: _(____)____-____

First Annual SC Vistula Soccer Player Development Camps

Location: Dolphine Park, 2 Dolphine Parkway, Garfield, NJ 07026

Soccer Camp Fees: 1 week \$150 or 2 weeks for \$250 (Vistula Registered Players receive 10% discount)

Form with payment can be mailed by July 17th to: SC Vistula, PO Box 496, Garfield NJ 07026 or commitment can be emailed to camps@vistulasc.com.

Select Camp Dates attending below.

	<u>Full</u>	<u>Discount</u>
<input type="checkbox"/> July 20 th to July 24 th , 5:00PM – 8:00PM	___\$150	___\$135
<i>Technical Development</i>		
<input type="checkbox"/> July 27 th to July 31 st , 5:00PM – 8:00PM	___\$150	___\$135
<i>Game Intelligence</i>		
<input type="checkbox"/> Both above weeks	___\$250	___\$225
<input type="checkbox"/> Shirt Size		

YS: ____ YM: ____ YL: ____ AS: ____ AM: ____ AL: ____ AXL: ____

Make checks payable to **S.C VISTULA GARFIELD** (there is a \$30.00 fee for returned checks)

NOTE: Registration is not complete without initials on first & second page bottoms and signed third page.

Parent Initials: _____

OFFICIAL USE CLUB ONLY:

Received by (Signature): _____ Date: ____/____/____

Fee Received: Full: ____ Amount: ____ Payment Type: _____



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RELEASE OF LIABILITY

READ CAREFULLY

I, the participant understand that attending the programs at Dolphine Park located at 2 Dolphine Parkway, Garfield, NJ, 07026 and the facilities does so at his/her own risk. The City of Garfield / SC Vistula and its owners, employees or agents, shall not be liable for any damage whatsoever arising from any personal injury or property loss sustained by participant with his/her family in or about any programs on the premises. Participants and family members assume full responsibility for all injuries and damages which occur in or about any programs on the premises,

The participant does hereby fully and forever release discharged hold harmless The City of Garfield / SC Vistula, all associated facilities and its owner, employees, and agents from any and all claims, demands, damages or rights of action, present or future resulting from any person's participation in any programs or use of the facility. In addition, the participant agree(s) to follow the rules of conduct and play set by The City of Garfield / SC Vistula. Failure to do so may result in suspension from participation.

Consent:

I do hereby grant authority to the staff at The City of Garfield / SC Vistula to render a judgment concerning medical assistance or hospital care in the event of an accident or illness during where the participant is unable to make their own decision. I do hereby authorize The City of Garfield / SC Vistula and its assigns to utilize any and all photographs, pictures or other likeness of me or anyone assigned guardianship to me, as they deem appropriate in its promotional materials or team films.

Name/Print

Date

Signature



Parent Initials: _____

SC VISTULA GARFIELD REGISTRATION FORM SOCCER CAMP

As a parent or guardian of _____, a minor, I hereby authorize the treatment by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger my child's life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Parent/Guardian Full Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Home Phone: _(____)____ - _____ Cell Phone: _(____)____ - _____

Emergency Contact Name: _____ Phone: _(____)____ - _____

Relationship to Athlete: _____

Emergency Contact Name: _____ Phone: _(____)____ - _____

Relationship to Athlete: _____

Family Physician: _____ Phone: _(____)____ - _____

Indicate specific medical allergies, chronic illnesses, or other medical conditions that coaches and medical personnel should be aware of:

This release is completed and signed of my own free will for the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Parent/Guardian Signature: _____ Date: ____/____/____