



RAIDER VOLLEYBALL CAMP

Monday- Thursday August 5-8

Williamsburg High School Gymnasium

5th – 6th Grade | 10:00AM – 12:00NOON

CAMP FEE \$40.00

PLEASE BRING THIS FORM AND YOUR \$40.00 CAMP FEE WITH YOU TO THE FIRST DAY. IF YOU DO NOT HAVE THIS FORM FILLED OUT, YOU WILL NOT BE ABLE TO PARTICIPATE – COACH BUSCH

Athlete Name _____

Parent's Name _____ Phone (____) _____

Email Address _____

T-Shirt Size (Please Circle) YS YM YL S M L XL

Grade Entering (Please Circle) 5th 6th

As a parent and/or guardian, I do hereby give my permission to an authorized representative of the Williamsburg Volleyball Program to obtain professional medical attention for my child in case of injury or illness; if I cannot be located. I understand that I AM responsible for all cost involved.

I do hereby authorize treatment by a qualified and licensed physician of the following minor in the event of a medical emergency which, in the opinion of the attending physician, if delayed. This authority is granted only after a reasonable effort has been made to reach me.

NAME OF MINOR CHILD _____

THIS RELEASE FROM IS COMPLETED AND SIGNED OF MY OWN FREE WILL WITH THE SOLE PURPOSE OF AUTHORIZING MEDICAL TREATMENT UNDER MEDICAL EMERGENCY CIRCUMSTANCES IN MY ABSENCE.

SIGNATURE _____ Date _____

Parent Signature _____ Date _____