



CENTRAL WASHINGTON UNIVERSITY

*Athletic Department*

CWU is an AA/EEO/Title IX Institution. TDD 509-963-2143.

# **NON-CONTACT YOUTH FOOTBALL SKILLS CAMP 2010**

**MAY 8**

**9 a.m. – 11:30 a.m.**

**CWU PRACTICE FIELDS**

**NICHOLSON PAVILION**

**CAMP IS OPEN TO GRADES 3-8**

**COST: \$20 PER CAMPER**

**REGISTRATION MAY 8 @ 8:30 a.m.**

***(ALL FORMS AND PHYSICALS MUST BE COMPLETED FOR  
PARTICIPATION)***

**CONTACT:**

**STACY COLLINS, CAMP COORDINATOR**

**PHONE: 509-963-1935**

**E-MAIL: [scollins@cwu.edu](mailto:scollins@cwu.edu)**

Date \_\_\_\_\_

Each participant is required to bring a **CWU HEALTH/EMERGENCY INFORMATION FORM** to the camp. Forms are available online at: **www.wildcatsports.com**. All Central Washington University (CWU) campers are required to provide a **non-returnable** physical fitness statement from their physician, a medical release, and proof of their own medical insurance prior to their participation in the CWU Camp.

**CAMPERS WILL NOT BE ALLOWED TO PARTICIPATE WITHOUT THESE FORMS.**

THIS FORM AND A VALID PHYSICAL FITNESS STATEMENT MUST BE PROPERLY SIGNED and RETURNED BEFORE THE FIRST DAY OF CAMP.

Students will not be allowed to participate without properly completed and signed forms.

Participant's Name \_\_\_\_\_

(Please print)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
(Month/Day/Year) (Area Code)

Camp Dates \_\_\_\_\_

**DOES YOUR CHILD HAVE:**

Allergies  Yes  No If yes, list. \_\_\_\_\_

Chronic Illness, such as heart condition, asthma, epilepsy, diabetes, etc.  
 Yes  No If yes, list. \_\_\_\_\_

Has your child had any injuries and/or operations during the past year?  
 Yes  No If yes, list type and dates. \_\_\_\_\_

Has your child's physical activity been restricted during the past year?  
 Yes  No If yes, list reasons and duration. \_\_\_\_\_

Is your child taking any medications?  Yes  No If yes, why? \_\_\_\_\_

Name of medication(s) and Dosage(s). \_\_\_\_\_

Has your child ever taken any sulfa drugs?  Yes  No  
Has your child had adverse reactions to any drugs?  Yes  No  
If yes, list drug(s) and reaction(s): \_\_\_\_\_

Date of last tetanus immunization: \_\_\_\_\_

I, the undersigned, individually and as a parent/guardian of \_\_\_\_\_ (participant),

a minor, ask that he/she be admitted to participate in the sports camp sponsored by Central Washington University.

I am fully aware of the safety risks of participating in this activity. I acknowledge and accept the risks and I understand that CWU cannot guarantee my child's safety. I state to you that I am not aware of any physical condition that would limit my child's participation in this activity. I understand that it is my responsibility to let you know if my child has any condition that would limit his/her ability to participate safely in this activity.

In exchange for my child's being allowed to participate in this activity, and to the fullest extent permitted by law, I hereby waive and release—and further agree to indemnify, defend, and hold harmless Central Washington University and its trustees, officers, agents, employees, and volunteers from and against—any and all liabilities,

claims, costs, expenses, injuries, and or/losses that I or my minor child may sustain as a result of my child's attendance at the sport camp or in the course of competition and/or activities held in connection with the sport camp.

I hereby give consent for medical treatment and agree to assume all responsibility for payment of medical bills and expenses. Furthermore, I will be responsible for filing all claims with all insurance companies. You have my permission to release a copy of this form and the personal insurance information below to any medical provider treating my child.

I also give permission for my child's photograph to appear in promotional material regarding future camps.

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

\_\_\_\_\_  
(Please print name and relationship to participant)

**IN CASE OF EMERGENCY, NOTIFY:**

Name \_\_\_\_\_

(Please print)

Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Work (\_\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_\_) \_\_\_\_\_  
(Area Code) (Area Code)

Family Physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
(Area Code)

Medical Insurance \_\_\_\_\_

Name of Insured \_\_\_\_\_

Policy/Group # \_\_\_\_\_