



CAMPER INFORMATION

Camper Name _____

Male Female Age: _____

Birth day: _____ T-Shirt: L M S YL YM YS
Circle One

Address _____

City, State, Zip _____

Phone _____

Emergency Phone _____

Email _____

Parent / Guardian Signature _____

Picture Release:
As a parent or guardian of a participant in this program, I give the Cascade Surge permission that any picture taken during soccer camp, which may include my participant can be used for future promotion purposes, such as newsletters, brochures, websites, etc.

PLEASE CHECK APPROPRIATE BOX (S)

CAMP OPTIONS	TIME	PRICE
<input type="checkbox"/> Keizer Camp Half Day	9:00 am to Noon	\$85.00
<input type="checkbox"/> Keizer Camp Full Day	9:00 am to 4:00	\$170.00
<input type="checkbox"/> South Salem Half Day	9:00 am to Noon	\$85.00
<input type="checkbox"/> South Salem Full Day	9:00 am to 4:00	\$170.00
<input type="checkbox"/> Surge Player Academy	9:00 am to Noon	\$125/140
<input type="checkbox"/> Goalkeeper Academy	1:00 pm to 4:00	\$125/140
<input type="checkbox"/> Lunch Option		\$20.00

Mail or Online Registration

If registering by mail, send a non-refundable \$50 deposit with this form (player registration and medical release) to:
Cascade Surge Soccer Camps
P.O. Box 2689
Salem, OR. 97308

Balance due one week prior to the start of camp

If registering online, visit www.cascadesurge.com and proceed with the registration process. Online registration requires payment of full amount via credit/debit card.

Method of Payment

Check Visa MasterCard

Credit Card # _____ Exp. date _____

Signature _____

MEDICAL RELEASE / LIABILITY WAIVER

As the parent/legal guardian of the child named above, I request that in my absence the above-named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital of medical facility to dispose of any specimen or tissue taken from the above-named player.

I acknowledge reading the information provided and (where applicable) agree to the published waiver.

Parent / Guardian Signature _____

Date _____