

Print this form and return with check

AVC INCOMING FRESHMEN CAMP

August 2nd-5th

REGISTRATION FORM

PLAYER NAME _____ PARENT NAME _____

EMAIL _____ HOME ADDRESS _____

CITY _____ ZIP _____

HOME PHONE _____ CELL _____

EMERGENCY PH # _____ NAME _____

GRADE IN FALL _____ D.O.B. _____

SCHOOL _____ CLUB _____

I hereby authorize the staff of the Absolute Volleyball Club to act for me according to their best judgment in any emergency requiring medical attention and I hereby wave and release the Absolute VB club from any and all liability for any injury or illnesses incurred while at the camp. The Absolute VB camp staff has my permission to seek any emergency medical treatment deemed necessary for my child while in attendance at the program named above.

Parent/Guardian Signature *Date*

Cost for AVC players is \$120 per clinic
Cost for non AVC players is \$140 per clinic

AMOUNT PAID: _____ *Checks payable to Absolute Volleyball Club*
CHECK NUMBER: _____

Please fill out registration neatly and mail form with check to:

*Absolute Volleyball Club
4460 Redwood Highway #16-364
San Rafael, CA 94903*