



2012 Team Camp Registration Form

Camper's Name: _____

Email address: (To which the following information will be confirmed) _____

Coach's Name: _____ Coach's Email _____

Resident Campers: \$275 - If a coach decides to check out after breakfast of the fourth day, the total cost will be \$290. Resident campers paying \$275 will check out after the evening session of the third night. Please talk to your coach to determine what option to select! All meals and lodging are included on resident camper rates.

Commuter Campers: \$190 - Lunch and dinner are included in commuter fee.

All camp registrations should be given to your head football coach. He will mail everything in as a team to SVS Inc.

Please check the camp(s) you will be attending:

- Resident Camper - 3 Days and 2 night stay \$275.00
- Resident Camper - 4 Days and 3 night stay \$290.00
- Commuter Camper \$190.00
- Resident Camper - 2 Days and 1 night stay \$200.00 (Millersville Only– July 21-22)
- Commuter Camper \$175.00 (Millersville Only– July 21-22)

- | | |
|---|---|
| <input type="checkbox"/> July 20 - 22 West Chester Team Camp | <input type="checkbox"/> July 21 – July 22 Millersville Team Camp |
| <input type="checkbox"/> July 27 - 29 West Chester Team Camp | <input type="checkbox"/> July 28 – July 30 Millersville Team Camp |
| <input type="checkbox"/> July 30 – Aug 1 Shippensburg Team Camp | |



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Email address to which the following information will be confirmed

Last name First Name Middle Initial

Home Address

City State Zip Home Phone

Emergency contact name Emergency contact phone

Height Weight Age Grade:(next fall) Position

School name Location: (city, state)

Mother's name Mother's phone

Father's name Father's Phone

SVS T-Shirt size: (not applicable for all camps) S M L XL XXL XXXL

SECURITY DEPOSIT: Team Camps:

Each player attending Team Camp or will be required to make a \$50.00 deposit, refundable upon checkout. Please do not mail security deposit. It will be collected by your coach prior to check-in. I understand that I will lose my \$50.00 security deposit if any of the following would happen: damage to my room, damage to my hallway, damage to the bathroom facility on my floor, pulling or tampering with the fire alarm on my floor, I am dismissed from camp, I lose my room key or combination card. I also understand that if the damages exceed the \$50.00 security deposit that my parent and I will be billed. Note. If a fire alarm is pulled, everyone on the floor will lose their deposit. I will take full responsibility for any of the above problems and fully understand that I could lose my security deposit.

Sign _____ Date _____

Refund Policy:

No cash refunds for underclassmen. All underclassmen will receive a credit to attend future SVS camps. If you do not notify SVS Sports, Inc. in writing at least one week before the start of the camp, there will be no credit given. There will be no exceptions. Cash refunds will only be given to seniors and a \$100.00 service charge will be applied. All refund checks will be mailed at the end of August.

Total Amount Enclosed: _____

Make all checks payable to: Jim Cantafio
SVS Sports, Inc 133 Bank Barn Lane Lancaster, PA 17602
Have Questions? Call Jim Cantafio (717) 468-718



2012 Medical Release Form

Last Name	First Name	Middle Initial
_____	() _____	() _____
School	Mother's Daytime Phone	Father's Daytime Phone

In the event that I am unavailable for the purpose of providing parental consent, I hereby authorize the physician(s) and staff at the local hospital to provide such care that routine diagnostic procedures and medical treatment as necessary to my minor son/daughter. I understand the consent and authorization herein granted do not include major surgical procedures and are only valid during camp.

This camp does not provide medical insurance for campers. In the event of illness or injury requiring treatment or hospitalization, family medical insurance must be used. Parents will be billed directly for any medical care given at the College Health Center or local hospital.

Physical conditions that the physician should be aware of: allergies, recurring illness, disabilities, chronic illness, etc.

Date of most recent tetanus immunization: _____ (if more than 10 years ago, a booster is recommended)
I understand that I will be contacted during the child's examination in the emergency department.

If I am not available, contact: _____ Phone: () _____

My family physician is: _____ Phone: () _____

Insurance Company Name: _____

Policy Number: _____

Group Number: _____

Father or Mother's name that the insurance is under: _____

Insured Birthdate: _____

Place of Employment: _____

Parent/Guardian's Name (Please Print)	Signature	Date
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