

**2009 FOOTHILL VOLLEYBALL
CAMP REGISTRATION FORM
July 27-30 and August 10-13**

PRINT: PARTICIPANT'S NAME _____

ADDRESS: _____ APT. NO. _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (____) _____ EMAIL: _____

WHICH CAMP ARE YOU ATTENDING? CHECK ONE:

- MIDDLE SCHOOL CAMP 1: 9 a.m. - 12 p.m. Grades 5th-8th. July 27-30, 2009
 HIGH SCHOOL CAMP: 1p.m. - 4 p.m. Grades 9-12, July 27-30, 2009
 MIDDLE SCHOOL CAMP 2: 9am-12pm, Grades 5th-8th, Aug. 10-13, 2009

WHAT SIZE T-SHIRT? CHECK ONE:

- YOUTH SM YOUTH MED YOUTH LG ADULT SM ADULT MED ADULT LG ADULT XL

COST: \$200 PER SESSION

**PLEASE MAKE CHECKS PAYABLE TO:
FOOTHILL COLLEGE WOMEN'S VOLLEYBALL**

**SEND CHECKS TO:
KATY RIPP
FOOTHILL COLLEGE
12345 EL MONTE RD.
LOS ALTOS HILLS, CA 94022**

PARTICIPANT'S RELEASE OF CLAIMS

I, _____, wish my son / daughter
(print your name) (circle one)

_____ born on _____
(print your child's name) (child's date of birth)

To participate in the Foothill Volleyball Camp, located at Foothill College and offered by Foothill College. As his/her parent, and on my child's behalf, I make the following statements voluntarily, and with full intent that they be relied upon:

I understand and acknowledge that Volleyball is a POTENTIALLY RISKY ACTIVITY in which my child might be INJURED. I understand that it carries this risk whether or not conducted reasonably, or with negligence, by the College or other participants. Foothill College is willing to allow this activity to occur on College property but cannot guarantee my child's safety if he/she participates.

I therefore RELEASE the College; its officers and employees, from LIABILITY OF ANY KIND ARISING OUT OF ANY INJURY TO MY CHILD, HOWEVER SERIOUS, and WHICH OCCURS BECAUSE OF OR IN CONNECTION WITH THE ACTIVITY. I further agree that this RELEASE SHALL APPLY EVEN IF MY CHILD'S INJURY IS CAUSED BY NEGLIGENCE OF THE COLLEGE OR ITS OFFICERS AND EMPLOYEES. On behalf on my child, myself, my guardians, heirs and estates, I COVENANT NOT TO SUE the College or its employees in the event he/she is injured.

Date Signature of Participant's Parent/Guardian

MEDICAL TREATMENT RELEASE

If my child is injured while participating in the Foothill College Volleyball Camp, I hereby consent to he/she receiving emergency medical treatment at the scene, and if necessary ambulance transportation to an appropriate hospital or other medical care center.

Date Signature of Participant's Parent/Guardian

(____) _____
Daytime phone number & Contact Person

(____) _____
Emergency Phone Number & Contact Person

Please return completed and signed form along with payment to:

Katy Ripp, Women's Volleyball
Foothill College
12345 El Monte Road
Los Altos Hills, CA 94022

If you have any questions, please email RippKaty@foothill.edu or call (650) 949-7355.