



***VALLEY CATHOLIC BOYS SOCCER  
FITNESS CAMP***

Monday, August 5 – Wednesday, August 7

5:00-7:00pm

Cost: \$50

Valley Catholic Turf Field

Head coach Mike Chertude will be running this camp.

Complete the registration form and mail or bring to camp.

Checks should be made to Valley Catholic.

Registration can be mailed to:

Valley Catholic Athletics

Mike Chertude

4275 SW 148<sup>th</sup> Ave

Beaverton, OR 97078

**OR**, you may email coach Mike Chertude at [mchertude@valleycatholic.org](mailto:mchertude@valleycatholic.org) with the name and grade of the participant and then bring the registration and fee the first day of the clinic.

## VALLEY CATHOLIC BOYS SOCCER FITNESS CAMP

### Registration Form

Player's Name: \_\_\_\_\_

Parent's Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

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

Contact Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Alt. Phone (in case of Emergency): \_\_\_\_\_

School: \_\_\_\_\_

Current Grade: \_\_\_\_\_

#### Medical Consent and Insurance

We, the undersigned parents or guardians, hereby grant permission for our child, \_\_\_\_\_ to participate in the Valley Catholic Soccer Fitness Camp. In consideration of being permitted to use the facilities, I hereby release said Valley Catholic School and its trustees, administrators, and employees from any and all liability for any damage or injury that any participant or my daughter may incur while on the premises of said school, both as to any right of action that may accrue to myself, my heirs and personal representative. This release includes all claims, demands, rights, and causes of whatsoever kind of nature arising from, and by reason of, any and all known and unknown, foreseen and unforeseen bodily and personal injuries, damage to property and the consequences thereof, that hereafter may be sustained.

It is further understood and agreed that, I hereby authorize VALLEY CATHOLIC SOCCER FITNESS CAMP and its employees to secure the necessary medical services for my child in the event of an accident or illness. Further, I will be solely responsible for the payment of the services.

Parent/Guardian Signature:

\_\_\_\_\_

The participant has medical insurance with: \_\_\_\_\_ Policy #: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Dr. Phone #: \_\_\_\_\_

List any allergies or pertinent physical conditions: \_\_\_\_\_

\_\_\_\_\_