



SOCCER CAMP 2009 APPLICATION

(415) 497-8164 • Email: fionasoccercamps@yahoo.com • www.fionasoccercamps.com

Last Name: _____ First Name: _____ Age: _____ Boy Girl

Address: _____

Phone: () _____ Cell Phone: () _____

Parent/ Guardian name: _____ Parent's email: _____

List any medical conditions or restrictions: _____

Person to notify in an emergency: _____ Phone: () _____

Doctor to notify in an emergency: _____ Phone: () _____

DATES

- Session 1: July 13-17, Monday-Friday
- Session 2: July 20-24, Monday-Friday
- Session 3: July 27-31, Monday-Friday

PRICES

- Full Day: 9am-3pm..... \$225 _____
- Half Day/Morning: 9am-Noon..... \$175 _____
- Half Day/Afternoon: Noon-3pm \$175 _____

DISCOUNTS

- WMYSL Players: Full Day \$200/each _____
- Team Discount: 5 or more players, Full Day \$200/each _____
- Sibling Discount: 2nd or more, Full Day \$205/each _____

OPTIONAL

Extended Camp: 8:30-5pm

- Extra per week \$65/week _____
- Extra per day..... \$30/day _____

Check # _____ **Total Amount** _____

Camp Location:

Whitehill Middle School
101 Glen Dr.
Fairfax, CA 94930

Bring Your Own:

SOCCER BALL
WATER BOTTLE
LUNCH
SHINGUARDS
CLEATS

Make check payable to:

Fiona's WM Soccer Camp

Mail to:

Fiona's WM Soccer Camp
P.O. Box 129
San Geronimo, CA 94963

**Application and payment
due by June 19, 2009**

I, the parent/guardian of the above named player, agree that the player and I will abide by the rules and regulations of the U.S. Youth Soccer (USYS) and its affiliated organizations. I hereby release, discharge and otherwise and indemnify and hold harmless the USYS, the WMYSL and affiliated parties, the owners and operators of the facilities used for the program and their respective directors, officers, agents and representatives, Fiona O'Sullivan, Maureen Healy, and Aidan O'Sullivan from and against all claims, liabilities, damages or causes of action arising out of or in connection with the player's participation in Fiona's Soccer Camp. As the parent of legal guardian of the above named player, I hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever circumstances are necessary to preserve the life, limb or well being of my dependent.

Parent Name: _____ Signature: _____ Date: _____