

Application and Consent
TVA-WS Youth Volleyball Camp

Camper's Name: _____
Email: _____
Birth date: _____
Address: _____
City: _____ State: _____ Zip: _____
School: _____
Coach: _____ Coaches Email: _____

Camp Dates:

- Camp 1: June 22 - June 26
- Camp 2: July 6 – July 10
- Camp 3: July 27 – July 31
- Camp 4: August 3 – August 7

Camp Fees: \$155 per week

- T-shirt and Kneepads included
- Lunch not included

Entire payment and any remaining paperwork must be received by June 15, 2009. A \$25.00 processing fee will be charged on any refunds. There will be no refunds after June 15, 2009.

Make Checks Payable to: TVA Inc.

Mail to: The Volleyball Academy Inc.
 P.O. Box 5867
 Winter Springs, FL 32719

PARENTS MUST READ, COMPLETE, AND SIGN THE ENTIRE CONSENT FORM.

This includes the Waiver of Liability, Medical Insurance, and Physician's Statement.

Consent to Medical Treatment and Release of Liability:

In consideration of being allowed to participate in this camp I hereby RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE Seminole County Public Schools, Winter Springs High School, and The Volleyball Academy @ Winter Springs, and their employees (hereinafter referred to as RELEASEE) from any and all liability, claims, demands, or course of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by me/my child, or to any property belonging to me/my child, WHETHER CAUSED BY THE NEGLIGENCE OR THE RELEASEE, or otherwise, while participating in this camp, or while in, on or upon the premises where the camp is being conducted.

To the best of my knowledge, I/my child am/is in good physical condition and I am not aware of any physical infirmity which would place me/my child at risk to participate in any way with the camp's activities. I am fully aware of risks and hazards connected with this camp. I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISK OF LOSS, PROPERTY DAMAGE OR PERSON INJURY, INCLUDING DEATH, that may be sustained by me/my child, or any loss or damage to property owned by me/my child, as a result of being engaged in the camp's activities, WHETHER CAUSED BY THE NEGLIGENCE OF RELEASEE or otherwise. I further hereby AGREE TO INDEMNIFY AND HOLD HARMLESS the RELEASEE from any loss, liability, damage or cost, including court costs and attorneys' fees, that may accrue related to my/my child's participation in the camp. WHETHER CAUSED BY NEGLIGENCE OR RELEASEE or otherwise

During the period of the camp, I hereby give permission for the staff, of the Winter Springs High School Athletic Trainer or this camp to administer appropriate medical attention to me/my child in the event of any accident, illness, or injury. I will be responsible for any and all costs of medical coverage and treatment provided not covered by insurance.

It is my express intent that this Waiver of Liability and Hold Harmless Agreement/Consent to Medical Treatment shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representative, if I am deceased, and shall be deemed as a RELEASE, WAIVER, this Waiver of Liability and Hold Harmless Agreement/Consent to Medical Treatment shall be construed in accordance with the laws of the State of Florida. In signing this release, I acknowledge and represent that I have read and understand it and sign in voluntarily; I am at least eighteen (18) years of age and fully competent; and I execute this Release for full, adequate and complete considerations fully intending to be bound by same.

I HAVE READ THIS WAIVER OF LIABILITY AND FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

PARENT/GUARDIAN'S SIGNATURE Date Signed

Print Camper's Name Emergency Phone Number(s)

Medical Insurance Company: _____
Policy Number: _____ Group Number: _____
Insurance Company Phone Number: _____
Name on Policy: _____

PHYSICIAN'S STATEMENT:
I hereby certify that _____ has no restrictions which would prevent him/her from active and full participation in any and all activities related to the Camp.

Doctor signature: _____ Date: _____

Known allergies Tetanus Booster Date

Medication camper will bring to camp, if any

COPY OF PHYSICAL (COMPLETED WITHIN ONE YEAR OF CAMP) ACCEPTABLE IN LIEU OF PHYSICIAN'S SIGNATURE