

# DEGA DA GAMA VOLLEYBALL CAMPS – 2020

## REGISTRATION FORM:

Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Height \_\_\_\_\_  
Grade Entering in Fall \_\_\_\_\_ T-Shirt Size (circle one) Youth M L Adults S M L XL  
Position \_\_\_\_\_ E-mail \_\_\_\_\_  
School \_\_\_\_\_ Club \_\_\_\_\_ HS Coach's Phone \_\_\_\_\_  
Skills Camps - July 26<sup>th</sup> to 29<sup>th</sup> - 7<sup>th</sup>-12<sup>th</sup> grade - Overnight \$419 \_\_\_\_\_ Commuter \$399 \_\_\_\_\_

Team Camps - July 29<sup>th</sup> to July 31<sup>st</sup> - 7<sup>th</sup>-12<sup>th</sup> grade - Overnight \$319 \_\_\_\_\_ Commuter \$299 \_\_\_\_\_

\*Middle School Camps – July 31<sup>st</sup> to August 2<sup>nd</sup> - 5<sup>th</sup>- 8<sup>th</sup> gr. - Overnight \$319 \_\_\_\_\_ Commuter \$299 \_\_\_\_\_

**\* We cannot allow anyone under the age of 12 to stay on campus overnight.**

**Medical - Release** Approval Name of Camper \_\_\_\_\_  
Age \_\_\_\_\_ Name of Team (Team Camps) \_\_\_\_\_  
Grade \_\_\_\_\_ Past Health \_\_\_\_\_ Past Injuries \_\_\_\_\_  
Present Medications? \_\_\_\_\_ Drug Sensitivities? \_\_\_\_\_  
Other Allergies? \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_ Policy Holder \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ State \_\_\_\_\_ Cell  
Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Phone # for 2nd adult \_\_\_\_\_

I verify that my child/ward has been checked by a licensed physician and is physically able to participate in the ABCD Sports Volleyball Camp LLC. I understand that participation in the camp will involve instruction in the sport of volleyball and may include vigorous physical exercise or activity involving a multitude of risks, including but not limited to, broken bones, sprains, muscle pulls and head injuries. In consideration of my child/ward being able to participate in this Volleyball Camps, I hereby agree and promise that I will not hold ABCD Sports LLC nor its employees responsible for any loss, damages, or personal injury received as a result of my child/ward's participation or the conduct of camp directors and/or employees, including negligence. I hereby authorize the directors of the Dega da Gama Volleyball Camp (ABCD Sports LLC) to act for my child/ward according to their best judgment

\_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian Signature

\*Please make checks out to Dega Da Gama Volleyball Camp and send with registration and medical release forms to 2500 North River Road - Manchester, NH 03106. For more information please call (603) -722 4115 or e-mail [coachdagama@gmail.com](mailto:coachdagama@gmail.com)