

# Concordia Soccer Camps

Please print clearly – incomplete or illegible forms will not be processed. Please submit this form by mail or online (email). Payment must be submitted at time of enrollment. Enroll online now @ [www.cuieagles.com/sport/0/4.php](http://www.cuieagles.com/sport/0/4.php)

## Participant Contact Information

Participant's Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Contact \_\_\_\_\_ Phone \_\_\_\_\_

School \_\_\_\_\_ Grade this fall \_\_\_\_\_ HS Grad Year \_\_\_\_\_

How did you hear about this camp? \_\_\_\_\_

Parent/Contact email \*REQUIRED\* \_\_\_\_\_

## Emergency/Medical Information \*REQUIRED\*

Alternate Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Medical Ins. Company \_\_\_\_\_ Policy # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Any Medical, Physical or Emotional Conditions (including allergies and disabilities)? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

If **YES** please provide information to assist us: \_\_\_\_\_

Medications: **Yes** \_\_\_\_\_ **No** \_\_\_\_\_ List Medications (including inhalers) \_\_\_\_\_

Is your child up-to-date on all state-required immunizations? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

If **No**, please explain \_\_\_\_\_

Please list any other health information relevant to camp participation \_\_\_\_\_

**DAY CAMP: Mon-Fri 9am-12pm (Ages 9-14) \$125**

Team/Club \_\_\_\_\_ Yrs. Exp. \_\_\_\_\_

Position \_\_\_\_\_

**Nondiscrimination Statement** – In accordance with applicable Federal laws and University policy, Concordia University does not discriminate in any of its policies, procedures, or practices on the basis of race, religion, color, national origin, sex, sexual orientation, age or handicap.  
**Refund Policy** - Requests for refunds or transfers must be submitted in writing (email or mail) we cannot accept requests by phone. Requests must be received no less than 30 days prior to the first day of camp to qualify for a refund or transfer. Requests for refunds or transfers prior to 30 days will be processed and assessed a fee. No refunds or transfers are issued for requests received later than 30 days before the start of camp. Camps are not prorated and participant substitutions are not allowed. No refunds are given to campers dismissed from camp for inappropriate behavior.  
- Transfer fee is \$10.00 per transfer/per person  
- Cancellation Fee is \$50.00 per cancellation/per person

Payment total: \_\_\_\_\_ Make Checks Payable to "Concordia Soccer Camps" **Check#** \_\_\_\_\_

**Mail or Deliver completed enrollment form, waivers, and payment to:**  
Concordia Athletics Office, Attn: Soccer Dept. 1530 Concordia West, Irvine, CA 92612-3203  
Phone: 949.854.8002 x1432 E-Mail: cheyne.gordon@cui.edu

Participant's Name \_\_\_\_\_

*\*A separate waiver is needed for each participant per camp.*

Concordia University, Irvine  
Concordia Soccer Camps

**Waiver of Liability, Assumption of Risk, and Indemnity Agreement**

**Waiver:** In consideration of being permitted to participate in any way in the Concordia Soccer Camps that I have enrolled my child in, as listed on the Registration Form; hereinafter called "The Activity," I, for myself, my heirs, personal representatives or assigns, **do hereby release, waive, discharge, and covenant not to sue** Concordia University, Irvine, its officers, employees, and agents from liability **from any and all claims including the negligence of Concordia University, Irvine, its officers, employees and agents**, resulting in personal injury, accidents or illnesses (including death), and property loss arising from, but not limited to, participation in The Activity.

\_\_\_\_\_  
Signature of Parent/Guardian of Minor      Date

\_\_\_\_\_  
Signature of Participant      Date

**Assumption of Risks:** Participation in The Activity carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid such injuries. The specific risks vary from one activity to another, but the risks range from 1) minor injuries such as scratches, bruises, and sprains 2) major injuries such as eye injury or loss of sight, joint or back injuries, heart attacks, and concussions to 3) catastrophic injuries including paralysis or death.

**I have read the previous paragraphs and I know, understand, and appreciate these and other risks that are inherent** in The Activity. I hereby **assert that my participation is voluntary and that I knowingly assume all such risks.**

**Indemnification and Hold Harmless:** I also agree to INDEMNIFY AND HOLD Concordia University, Irvine HARMLES from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees brought as a result of my involvement in The Activity and to reimburse them for any such expenses incurred.

**Severability:** The undersigned further expressly agrees that the foregoing waiver and assumption of risks agreement is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

**Acknowledgment of Understanding:** I have read this waiver of liability, assumption of risk, and indemnity agreement, fully understand its terms, and **understand that I am giving up substantial rights, including my right to sue.** I acknowledge that I am signing the agreement freely and voluntarily, and **intend by my signature to be a complete and unconditional release of all liability** to the greatest extent allowed by law.

\_\_\_\_\_  
Signature of Parent/Guardian of Minor      Date

\_\_\_\_\_  
Signature of Participant      Date

Participant's Age (if minor) \_\_\_\_\_

Participant's Name (Last, First): \_\_\_\_\_

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# Concordia Soccer Camps – Medication Form

Name of camper \_\_\_\_\_ Date of Birth \_\_\_\_\_

FORM MUST BE COMPLETED BEFORE ANY MEDICATION IS BROUGHT TO CAMP

**This form must be completed for prescribed and non-prescribed medications by the parent/guardian and contain proper signatures before any medication can be administered at camp.** All medications, whether prescribed or non-prescribed, are kept in the camp office. If your physician would like your child to carry either an asthma inhaler or emergency medication (i.e. EpiPen or Inhaler), Part 3 must be completed by the doctor, parent, and child.

**Part 1: PARENT/GUARDIAN:** Both prescribed and non-prescribed medications will be administered by authorized camp personnel in the manner of dosage given. By signing below I hereby request that authorized personnel assist this camper in taking medication in the manner and dosage given. *I understand all medications must be in their original container.*

X \_\_\_\_\_  
Parent/Guardian Signature Printed Name/Relationship Date

( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Main contact phone Alternate Contact Phone

**Part 2: PHYSICIAN:** (Signature not needed if non-prescription medication) IF REQUIRED by Camp

Name of Medication \_\_\_\_\_ Form \_\_\_\_\_ Dose \_\_\_\_\_

Schedule of Doses \_\_\_\_\_ Date to Stop Medication \_\_\_\_\_

Restrictions, Cautions, Side Effects \_\_\_\_\_

X \_\_\_\_\_  
Physician Signature Printed Name/Relationship Date

Physician Phone # ( ) \_\_\_\_\_ Address \_\_\_\_\_

**Part 3: PERMISSION TO CARRY ASTHMA INHALERS/EPIPENS (Part 1 and 2 Must be completed)**

TO BE COMPLETED BY THE PHYSICIAN: The above-named camper has been instructed in the proper use of their asthma inhaler/emergency medication. The child's well-being is in jeopardy unless this medication is carried on his/her person. Therefore, I request that he/she be permitted to carry the asthma inhaler/emergency medication at camp. He/she understands the purpose, appropriate method, and frequency of use of asthma inhaler/emergency medication.

X \_\_\_\_\_  
Physician Signature Printed Name/Relationship Date

TO BE COMPLETED BY THE PARENT/GUARDIAN: I permit my child to carry the above-listed asthma inhaler/emergency medication as ordered by his/her physician.

X \_\_\_\_\_  
Parent/Guardian Signature Printed Name/Relationship Date

TO BE COMPLETED BY THE CAMPER: I have been instructed in the proper use of my medication and will take it as prescribed to mm by my physician.

X \_\_\_\_\_  
Camper Signature Printed Name/Relationship Date

**PART 4: CAMP DIRECTOR (to be completed by Health Care Coordinator/designated camp staff)**

Person(s) designated by camp Health Care Coordinator to assist camper in taking medication above

X \_\_\_\_\_  
Signature of Health Care Coordinator or designated camp staff Date

*This information to be used by Camp Director and authorized personnel only.*

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