College Soccer Training Center
Washington College
Registration Form

Player's Name_____

High School _____

High School Graduation Year (circle one) 2019 2020 2021 2022

Club Team _____

Club Coach _____

Preferred Position(s)_____

Weighted Grade Point Average_____

SAT Scores: Math_____ Critical Reading _____

Home Address_____

_____

Player's Email Address_____

Player's Cell# _____

Parents' Names_____

Parents' Email Address_____

Parents' Cell #s_____

Emergency Contact Information

Name _____ Relationship to athlete _____
Address _____ Home phone _____
_____ Cell phone _____

Insurance Information

Company or Plan Name: _____
Telephone #: _____
Policy Holder's Name _____ Policy Holder's DOB _____
Policy Holder's ID # (or SSN) _____

Group # _____ Policy # _____ Plan # _____

By signing this form, we acknowledge and accept the risk of injury associated with this participation in summer soccer camp. We are not aware of any medical conditions or health factors that would restrict our son's participation and have had a physical examination within the past 12 months, performed by a licensed medical doctor, stating that fact. In the event of an emergency, I give the Washington College Sports Medicine Staff or Team Doctor permission to evaluate or treat any injuries that occurred during this camp.

Athlete Signature _____ Date_____
Parent/Guardian Signature _____ Date _____
_____

For High School Team Camp:

Please make check deposit of $100 payable to: College Soccer Training, LLC

Remaining balance of $225 due 7/26/18

Mailing Address:

Roy Dunshee
Washington College Men's Soccer Office
300 Washington Ave
Chestertown, MD 21620-1197