



PA Classics Summer 2011 Camps & Academies Registration Form

Players Full Name: _____

Age: _____ Date of Birth: _____ Gender: (circle one) Male Female

Parents Name(s): _____

Contact Email: _____ Phone #: _____

Summer 2011 Striker/Goalkeeper Academy: \$95

Ages U13-U15: July 11-14, 2011, Mon-Thurs

Boys: 9:00 -11:00 am

Girls: 11:00 am - 1:00 pm

Ages U9-U12: July 18-21, 2011, Mon-Thurs

Boys: 9:00 -11:00 am

Girls: 11:00 am - 1:00 pm

Summer 2011 Midfielder and Defender Academy: \$95

Ages: U9-U15: July 25-28, Mon - Thurs

Boys: 9:00 am -11:00 am

Girls: 11:00 am - 1:00 pm

Summer 2011 Junior Academy Skill and Ball Mastery Program: \$50

Boys and Girls: August 22-25, 2011

Ages 4 - 6: 9:00 -10:00 am

Ages 7 - 8: 10:00 -11:00 am

For payment, check must be **paid in full** and made out to **PA CLASSICS**

Mail payment and registration form to:

Mark Pulisic, 907 Briarcrest Drive, Hershey, PA 17033

Medical Release Statement:

I, the parent / guardian of the registrant, a minor, or adult registrant of legal age, agree that I and the registrant will abide by the rules of the Pennsylvania Classics Athletic Club (PCAC) and its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer and in consideration for PCAC accepting the registrant for it's soccer programs, activities, and tryouts (the Programs), I hereby release, discharge, and/or otherwise indemnify PCAC, PA Soccer School and it's affiliated organizations and sponsors, their employees, volunteers, and associated personnel, including the owners of fields and facilities utilized for the Programs, against any claim by or on behalf of the registrant as a result of the registrant's participation in the Programs, and/or being transported to or from the game, tryout, scrimmage, event, group practice or other program which transportation I hereby authorize.

Consent for Medical Treatment (Minor):

As the parent or legal guardian of the registered player I hereby give my consent for emergency medical care provided by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb, or well being of my dependent. I hereby verify that all information is true and accurate. I understand that intentionally submitting untrue and/or false information could lead to eligibility disqualification, the duration to be determined by the executive board of Pennsylvania Classics Athletic Club (PCAC).

Parent's Signature: _____ Date: _____