Drop off check to the Grimes Community Complex made payable to: Cyclone Volleyball Camps

The **IOWA STATE CYCLONES** are putting on a camp

AT GRIMES COMMUNITY COMPLEX

ON 410 SE MAIN ST. JUNE 24 & 25

$40 per Camper

GOING IN TO GRADES 1-4: 9:00AM – 10:30AM

GOING IN TO GRADES 5-8: 10:30AM – NOON

MAX OF 20 PARTICIPANTS IN EACH TIME SLOT

Contact Brett Barber at bbarber@ci.grimes.ia.us or by phone at 515-986-2143

YOU WILL…

- ***IMPROVE*** as a an individual to prepare for the fall season
- Receive ***EXCELLENT*** skill instruction
- Receive a ***CAMP T-SHIRT***

Cyclone Volleyball Camp Liability Waiver

Participant Name _____ Grade (2013-14) _____

Address (Street, City, State, Zip) _____

Phone _____Email _____

School _____

Check T-Shirt Size: Youth: □ Med □ Large

Adult: □ Small □ Med □ Large □ XL □ 2XL

Release and Medical Authorization

The release & the treatment authorization must be signed by a parent or guardian if student is under 18 yrs old. Students who are 18 yrs old or will become 18 yrs old before the end of the camp/clinic must also sign. In order for students to participate in camp activities, we must have this form prior to the camp's start date. Otherwise, parent or guardian must be contacted prior to release to participate.

Release of Liability, Medical and Surgical Authorization

In consideration of the Cyclone Volleyball Camps of Iowa State University granting the student permission to participate in Cyclone Volleyball Camps, I hereby assume all risks of his or her personal injury (including death) that may result from any Cyclone Volleyball Camp activity. As guardian I do hereby release the State of Iowa, Iowa State Board of Regents, Iowa State University, Cyclone Volleyball Camps and their officers, employees, agents, all instructors, and all participants in said Cyclone Volleyball Camps from all liability, including claims and suits at law or in equity, for injury, fatal, or otherwise which may result from the student taking part in Cyclone Volleyball Camps activities.

In addition, I hereby authorize and give my consent to the health authorities of Iowa State University or any licensed health professional to perform upon or administer any reasonable, necessary surgical or medical treatment. I also give permission to administer whatever anesthetic may be necessary or advisable during the medical or surgical procedures. This authorization is intended to cover emergency treatment, immunizations, injections, and minor operations and procedures. In the case of psychiatric and/or psychological treatment, parent authorization for treatment beyond that responsive to the emergency will be requested. I agree to assume all costs related to such treatment. I authorize my insurance company to pay benefits to Iowa State University Health Service or other hospitals and clinics.

Parent's/Guardian's Signature_____Date_____

Student's Signature _____ Date_____

Also, I authorize the disclosure of medical information to my insurance company for purpose of claim. I understand that I will be responsible for any medical or other charges in connection with student's attendance at this camp. (Each camper must provide his/her own medical insurance.)

----------LOWER HALF NOT NEEDED FOR GRIMES SUMMER CAMP----------

Insurance Information (please print)

Name_____Insurance Company _____

Insurance Co. Address _____Policy No. _____

Policy Holder_____Does your insurance carrier require prior approval? Yes No

Medical Authorization **Required only if NO current (within one year of camp date) physical is available.**

This is to certify that this individual was examined by me on _____ (valid if within one year of camp) and that I found this individual to be physically able to participate in vigorous physical and competitive athletic sports. *School physical form acceptable if valid within one year of the starting date of camp.*

Date of physical exam _____ Allergies/Drug sensitivities _____

Other medical problems/current medications

_____

An identification band or card carried to alert others to the allergy(ies), medical conditions or medication use? Yes / No

Signed (Physician)_____ Date _____

Address _____Office Phone _____