MATT RHULE FOOTBALL CAMP

REGISTRATION FORM

1001 W. Diamond Street
Philadelphia, PA 19122
215.204.4694 (FAX) 215.204.0872

EDBERG-OLSON HALL
TEMPLE UNIVERSITY CAMPUS
5/29 6/4 6/11 6/12 7/30

CAMPER INFORMATION

CAMPER'S LAST NAME _____ FIRST NAME _____ MI _____

ADDRESS: _____ STREET _____ CITY _____

STATE _____ ZIP _____ CELL PHONE _____ HOME PHONE _____

SCHOOL (FULL NAME) / GRADUATION YEAR _____

T-SHIRT SIZE _____ HEIGHT _____ WEIGHT _____ DATE OF BIRTH _____

EMAIL ADDRESS -- This will be how you receive confirmation and all additional camp information.

Offensive Position (circle one) OL TE RB WR QB
Defensive Postion (circle one) DL LB DB

CAMP SESSION

INSTRUCTIONAL CAMP -- (check box to the left of date)
REGISTER BEFORE MAY 1ST: $45 PER CAMPER
REGISTER AFTER MAY 1ST: $55 PER CAMPER

- ☐ MAY 29TH
- ☐ JUNE 4TH — Entering Grades 9,10,11 ONLY
- ☐ JUNE 11TH
- ☐ JUNE 12TH
- ☐ JULY 30TH — Entering Grades 12 ONLY
- ☐ DIAMOND STREET DOUBLE — Check this box and select (1) additional camp date and pay just $25 more!
- ☐ TEMPLE TEAM DISCOUNT — Teams of 10 or more BEFORE MAY 1ST: $35 PER CAMPER; Teams of 10 or more AFTER MAY 1ST: $45 PER CAMPER
- ☐ LUNCH -- $7

PAYMENT

Please send payment through money order, credit card online, or cash. NO CHECKS ARE ACCEPTED.

CAMPER RELEASE

I, _____, the undersigned, individually and as a parent and guardian of _____, a minor agree that my child may participate in the Matt Rhule Football Camp ("Camp"). In consideration for permitting my child to so participate, I do here to full release, discharge and hold harmless Matt Rhule, individually, the Camp, and TEMPLE UNIVERSITY, including all managers, coaches, organizers, sponsors, supervisors, employees, or contractors, from any and all liability and all injuries my child may occur during the participation in the Camp. I understand my execution of this Release is a precondition to my child's acceptance and participation in the Camp. I do hereby further agree to indemnify and hold harmless Matt Rhule, individually, and the Camp, including all managers, coaches, organizers, sponsors, supervisors, employees or contractors in any action arising out of participation of my child in the camp.

MEDICAL TREATMENT AUTHORIZATION

In case of an emergency, I understand that every attempt will be made to contact me. If contact is unsuccessful, I give my permission to any attending physician and medical service personnel to tender medical treatment to my child, _____, including (if neccessary) hospitalization. I understand further that any expense arising from injury shall be my responsibility. I hereby authorize the staff of the Camp to provide care that includes routine diagnostic procedures (i.e., x-rays, blood and urine test) and medical treatment as necessary to my child, _____, a minor. In the event that an illness or injury would require more extensive evaluation, I understand that every reasonable attempt will be made to contact me. However, in the event that an emergency occurs, and if I cannot be reached, I give my consent for physicians and staff at Temple University Health Services to perform any necessary treatment. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider. Accident insurance for the Matt Rhule Football Camp is provided on an excess basis. All registrants must have their own primary responsibility of the parent or guardian's medical coverage on an as needed basis.

CAMPER HEALTH FORM

PARENT / GUARDIAN NAME (PRINT) _____ EMERGENCY CONTACT NUMBER _____

PARENT / GUARDIAN SIGNATURE _____ DATE _____

I understand that the consent and authorization herein granted does not include major surgical procedures and are valid only during the camp. Phyiscal conditions that clinicians should be aware of (allergies, recurring illness, disabilities, chronic illness, current medications) include: **PLEASE CHECK ALL THAT APPLY**

__ Asthma __ Diabetes __ Convulsions
__ Bleeding Disorders __ Heart Disease __ Rheumatic Fever
__ Concussions

Allergies to Drugs: _____
Last Physical Examination (date): _____
Last Tetanus Immunization (date): _____
Current Medications: _____
Chronic or Recurring Illnesses: _____
Operations/Injuries (dates): _____
Phyiscal Restrictions: _____
Physician Name/Phone #: _____
Policy Number: _____ Name of Employer: _____
Employer Phone #: _____ Name of Policy Holder: _____

PARENT / GUARDIAN NAME (PRINT) _____ EMERGENCY CONTACT NUMBER _____