

INTENSE SOCCER ACADEMY, LTD.
5036 Jericho Turnpike, Suite 305, Commack, New York 11725

SUMMER CAMP REGISTRATION FORM

NAME: _____ **DOB:** ____/____/____ **GENDER:** Male / Female

ADDRESS: _____ **PHONE:** _____-_____-_____

_____ **EMAIL:** _____

CELL (DAD): _____-_____-_____ **CELL (MOM):** _____-_____-_____

SOCCER CLUB: _____ **TEAM NAME:** _____

LEVEL OF PLAY (check one): Premier Div. 1 Travel/Div. 3 or lower pre-travel

I would like my child to participate in the following camp/clinic programs: *(please check all that apply)*

July 14-July 18 (Huntington) **July 28 – August 1** (Commack)

August 4 – August 8 (Commack) **July 21 – July 25** (Huntington) – invitation only

* all camps are 9:00-3:00pm

CAMPER STATUS

½ day camp full day camp

TUITION PER WEEK

\$295 (individual) \$250 (team/group)

EARLY REGISTRATION DISCOUNT

ALL TEAMS AND PLAYERS THAT REGISTER **ON OR BEFORE MAY 15, 2008** SHALL HAVE THE PRIVILEGE OF PAYING A **DISCOUNTED** WEEKLY TUITION OF **\$195 PER WEEK**.

Payment: make full payment payable to ISA and mail to 5036 Jericho Turnpike, Suite 305, Commack, NY 11725 together with this registration form.

Medical Release & Agreement to Hold Harmless & Defend Intense Soccer Academy, Ltd.

I, _____, PARENT/LEGAL GUARDIAN, OF _____
HEREBY AGREE TO INDEMNIFY, DEFEND AND HOLD HARMLESS INTENSE SOCCER ACADEMY, LTD. (TOGETHER WITH SUCH COMPANY'S SPONSORS, TRAINERS, STAFF, EMPLOYEES, CAMPERS, PARTICIPANTS AND PRINCIPALS) FROM AND AGAINST ANY AND ALL INJURIES THAT MY CHILD MAY SUFFER AS A RESULT OF PARTICIPATION IN ANY INTENSE SOCCER ACADEMY PROGRAM. I RECOGNIZE THAT SOCCER IS A CONTACT SPORT AND THAT IT MAY BE PHYSICALLY STRESSFUL AND TAXING ON MY CHILD. I FURTHER RECOGNIZE THAT MY CHILD'S PHYSICAL AND MENTAL HEALTH CONDITION MUST BE FULLY COMMUNICATED IN WRITING TO RON ALBER OF THE INTENSE SOCCER ACADEMY, LTD. PRIOR TO MY CHILD'S PARTICIPATION IN ANY OF THEIR PROGRAMS. IF I DO NOT COMMUNICATE ANY OF THIS INFORMATION IN WRITING TO RON ALBER OF THE INTENSE SOCCER ACADEMY, LTD., I WILL BE SOLELY RESPONSIBLE FOR ANY ADVERSE CONSEQUENCES. AS OF THE DATE OF THIS DOCUMENT, MY CHILD IS AFFECTED BY THE FOLLOWING PHYSICAL OR MENTAL HEALTH CONDITIONS: _____

x _____
parent/legal guardian of the above-named participant

Date: _____

PLEASE NOTE: NO REFUNDS WILL BE ISSUED AFTER THE FIRST DAY OF THE PROGRAM HAS COMMENCED.