



## **2023 Body Contact Positioning Camp**

**Cost: \$50/registration**

**Deadline to Register: September 30, 2023**

**Body Contact Positioning Camp October 22, 2023**

Registration is not complete until this form, payment and medical information have been received.

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### **Participant Information:**

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Gender:    Male    Female

Date of Birth: \_\_\_\_\_

(Please circle)

(day/month/year)

### **2023 Divisions (circle one):**

- U15 (2009 & 2010)
- U18 (2006, 2007 & 2008)
- If space is available this will open up to U13 (2011 & 2012)

### **Parent/Guardian Information:**

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Town: \_\_\_\_\_

Telephone: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Email: \_\_\_\_\_

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Town: \_\_\_\_\_

Telephone: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Email: \_\_\_\_\_

## Medical Information:

After returning the registration form, you will receive an email containing a link to the e-Pact online medical form. **If you have completed the medical information previously, you will still be asked to ensure that all information is up to date. Athletes will not be allowed on the field until the medical information is completed.**

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## Consent:

I understand and agree that this information is being collected for the purpose of Eston & District Recreation Committee and may be used to update the athlete of upcoming sports he/she may be interested in.

It is a condition of participation that the athlete does so at his/her own risk. The Eston & District Recreation Committee is not liable in any way for loss, damage or injury resulting from participation in this program.

I understand that it is the responsibility of the parent/guardian to keep the Recreation Director informed of any change in the above information as well as medical information as soon as possible. In the event of an injury, if no one can be contacted, staff may take my child to a hospital or doctor if deemed necessary. I authorize doctors and nursing staff to examine, investigate and treat my child as necessary.

I authorize release of information to the appropriate parties and photos of my child to be taken and used for promotional purposes.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

OFFICE USE ONLY	
Total: _____	Date Payment Received: _____
Staff Initials: _____	Receipt #: _____