

## The Tennis Camp Application

REGISTER AT [WWW.SPORTCAMPS.MSU.EDU](http://WWW.SPORTCAMPS.MSU.EDU)  
PLEASE PRINT INFORMATION BELOW OR ENROLL ONLINE

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_

Daytime Telephone: (\_\_\_\_\_) \_\_\_\_\_

Evening Telephone: (\_\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

Grade in September: \_\_\_\_\_ Age: \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

Roommate preference: \_\_\_\_\_

Suitemate preference \_\_\_\_\_ Suitemate preference \_\_\_\_\_

(A SUITE IS TWO ROOMS WITH CONNECTING BATH)

Shirt Size:  S  M  L  XL

Please enroll me in the following Tennis camp:

Camp Date	Resident	Commuter
<b>JULY 19-23</b>	<input type="checkbox"/> \$695.00	<input type="checkbox"/> \$425.00

U.S. FUNDS ONLY.  
Please make checks payable to  
**MICHIGAN STATE UNIVERSITY**

Check one:  CHECK  MASTERCARD  VISA

Card Number \_\_\_\_\_

3 digit security code \_\_\_\_\_ Exp. Date \_\_\_\_\_

Signature \_\_\_\_\_

Amount of Check/Charge enclosed \_\_\_\_\_

## Medical Treatment Authorization Form

Participant's Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

What Sport: Tennis

Date of Camp: July 19-23

Participants are automatically enrolled in MSU's accident insurance plan. Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance.

1. List any medical conditions that camp personnel should be aware of (use additional pages if necessary): \_\_\_\_\_

2. List any medications currently taking: \_\_\_\_\_

3. List any allergies: \_\_\_\_\_

### In case of emergency please contact:

Name \_\_\_\_\_

Daytime Telephone \_\_\_\_\_ Evening Telephone \_\_\_\_\_

Name of Medical Insurance \_\_\_\_\_ Company Telephone \_\_\_\_\_

Insurance Policy Numbers \_\_\_\_\_

\_\_\_\_\_, as parent or legal guardian of the participant named above, authorizes MSU to seek medical and/or surgical treatment which is reasonably necessary to care for the participant. I further authorize the medical facility that treats the participant to release all information needed to complete insurance claims. I acknowledge my responsibility to pay all costs associated with the participant's medical care and authorize all insurance payments, if any, to be made directly to the medical facility.

Signature (Parent or Guardian) \_\_\_\_\_ Date \_\_\_\_\_

Send Application and Medical Treatment Form with payment in full to:

**MICHIGAN STATE UNIVERSITY**  
Sports Camp Office  
402 Jenison Field House  
East Lansing, MI 48824-1025  
Fax: 1-517-355-6891