

The Cross Country Camp Application

REGISTER AT 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)

Number of years running: _____

Typical summer weekly running mileage: _____

Best performances: 400 _____ 800 _____ Mile _____ 3200 _____ 5K _____

Shirt Size: S M L XL XXL

Team: _____

Please enroll me in the following Cross Country camp:

Camp Date	Resident	Commuter
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JUNE 19-23	<input type="checkbox"/> \$350.00	<input type="checkbox"/> \$265.00
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5+ Team members = \$25.00 off per person

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: Cross Country

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