

Spartan Field Hockey Camp Application

REGISTER AT WWW.SPORTCAMPS.MSU.EDU

PLEASE PRINT INFORMATION BELOW OR ENROLL ONLINE

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Parent or Guardian: _____

Daytime Telephone: (_____) _____

Evening Telephone: (_____) _____

High School: _____

JV or Varsity (Circle one)

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: Small Medium Large X-Large XX-Large

Please enroll me in the following Field Hockey camp:

Camp Date	Resident	Commuter
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JULY 19-22	<input type="checkbox"/> \$450.00	<input type="checkbox"/> \$375.00
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JULY 26-29	<input type="checkbox"/> \$425.00	
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Airport Transportation from Lansing (\$30.00)

Airport Transportation from Detroit (\$60.00)

Early-arrival service (\$60.00)

U.S. FUNDS ONLY.

Please make checks payable to: **MICHIGAN STATE UNIVERSITY**

Card Number _____

3 digit code _____ Exp. Date _____

Signature _____

Amount of Check/Charge enclosed _____

Medical Treatment Authorization Form

Participant's Name _____ DOB ____/____/____

What Sport: Field Hockey

Date of Camp: _____

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, do hereby authorize the director of the sport camps and his or her subordinates, to seek any medical and/or surgical treatment which is reasonably thought to be necessary for the care of my child. The program director is authorized to provide medical treatment for my child, and I shall be fully responsible for honoring such costs. I also authorize the medical facility to release all information needed to complete insurance claims. I authorize insurance payment 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