

**October 2020**  
**MOUNTAIN RIDGE HIGH SCHOOL**  
**COMMUNITY SCHOOLS**  
**BOYS SOCCER CAMP**

WHEN: October 6, 8, 14, 15, 20, 21, 27, 29, November 3, 5  
WHERE: Patrick Lane Soccer Field. The field is adjacent to the tennis courts.  
TIME: 5:00 PM – 6:15 PM  
COST: \$50.00  
INSTRUCTORS: Andrew Lang, Janele Panousopoulos  
BRAIN BOOK: If you did **not** play or try out for soccer last season at MRHS, you must attach a printout of your brain book certificate. Go to [mrhs.dvusd.org](http://mrhs.dvusd.org), click on the "Athletics" tab and then, "Brainbook." If you need help, please contact me at [Andrew.Lang@dvusd.org](mailto:Andrew.Lang@dvusd.org).

\*\* All athletes must bring their own filled water bottle to camp each day. Masks must be worn to and from practice. Athletes should bring a backpack or bag to hold their water and mask during practice.

**REGISTRATION FORM**

PARTICIPANT'S NAME: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

To the best of my knowledge, this student/participant does not have any health problems that would be harmful to him/her while participating in this community schools program. Be it known that I, the undersigned parent/guardian/participant of the named student/participant, do hereby give and grant unto the instructor my consent and authorization to render such aide, treatment or care to said participant as, in the judgment of the instructor, may be required on an emergency basis, in the event said participant should be injured or stricken ill, it is hereby understood that the consent and authorization hereby given and granted are continuous, and are intended by me to extend through the length of the program. If emergency service involving medical action or treatment is required and neither the parents nor guardians can be contacted, I hereby consent for the participant to be given medical care by the doctor selected by the instructor. (Participant must have medical insurance to participate.)

NAME OF PARTICIPANT: \_\_\_\_\_  
PARENT/GUARDIAN/PARTICIPANT (if over 18) SIGNATURE: \_\_\_\_\_

INSURANCE COVERAGE COMPANY: \_\_\_\_\_  
POLICY NUMBER: \_\_\_\_\_ GROUP # \_\_\_\_\_

The Deer Valley Unified School District does not discriminate on the basis of race, color, national origin, sex, disability, or age in its programs and activities. Any inquires regarding nondiscrimination polices may contact the Superintendent's Office, 20402 N. 15<sup>th</sup> Avenue, Phoenix, Arizona 85027. 623.445.5000.

