



**JUNE 17<sup>TH</sup> – 21<sup>ST</sup> (9 – 11 AM)      GRADES 1 - 8      \$125/CAMPER**

**REGISTRATION/PAYMENT OPTIONS**

ONLINE:                      RMCFOOTBALLCAMPS.COM

MAIL-IN:                    FOOTBALL CAMP DIRECTOR  
103 E. PATRICK ST.  
ASHLAND, VA 23005

**CHECK-IN & CONTACT INFORMATION**

CHECK IN:                JUNE 17<sup>th</sup>, 8-8:30 RMC FOOTBALL OFFICE  
(TUNNEL OPPOSITE THE SCOREBOARD)

CONTACT:                PHIL NICOLAIDES                (804)752-3602  
PHILNICOLAIDES@RMC.EDU

**ALL CHECKS PAYABLE TO: PEDRO ARRUZA**

**WALK-UPS WILL BE ACCEPTED (FULL PAYMENT MUST BE PROVIDED AT CHECK-IN)**

**NAME:** \_\_\_\_\_

**YEAR IN SCHOOL (2019-2020)**      1<sup>st</sup>   2<sup>nd</sup>   3<sup>rd</sup>   4<sup>th</sup>   5<sup>th</sup>   6<sup>th</sup>   7<sup>th</sup>   8<sup>th</sup> (CIRCLE ONE)

**STREET ADDRESS:** \_\_\_\_\_ **CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**HOME PHONE:** (\_\_\_\_\_) \_\_\_\_\_ **PARENT'S CELL PHONE:** (\_\_\_\_\_) \_\_\_\_\_

**E-MAIL:** \_\_\_\_\_

**T-SHIRT SIZE: (CIRCLE PREFERRED)**      S      M      L      XL      XXL

**MEDICAL RELEASE**

I certify that the named Camper is physically fit for playing football and other related activities and has my permission to participate in the camp program. In case of an emergency, I understand that every attempt will be made to contact me. If contact is unsuccessful, I authorize the Randolph-Macon College Football Camp Medical Staff to perform immediate medical care, which includes but is not limited to the referral of other appropriate allied health care professionals, for any injury/illness that may occur while this individual is participating in camp activities. Any expense arising from injury is the responsibility of the person signing below.

I hereby authorize the staff of Randolph-Macon College to provide any care or medical treatment as deemed necessary to my minor son,

(Print Name): \_\_\_\_\_

I understand that the consent & authorization herein granted does not include major surgical procedures and are valid only during camp. Please list below any medications currently being taken or any allergies and/or medical conditions that might restrict this individual from participating in any camp activities:

\_\_\_\_\_

\_\_\_\_\_

If the participant has a medical condition that could require medicine during participation, it is the responsibility of the participant to supply this medicine daily (i.e. Asthma Inhaler).

I, the undersigned parent/guardian, certify that I have ensured that the participant has engaged in a sound nutritional diet which includes both hydration and food consumption, both before and after camp participation.

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

Emergency Phone: \_\_\_\_\_

Signed [Parent/Guardian]: \_\_\_\_\_