



**MINI ONE-DAY PROSPECT CAMP**

- TUESDAY, JUNE 5, 2018
- 7:00 - 9:30 PM
- RISING 10<sup>TH</sup> - 12<sup>TH</sup> GRADERS
- \$30/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 5<sup>TH</sup> 6:00 – 6:45 PM DAY FIELD  
(TUNNEL OPPOSITE THE SCOREBOARD)

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

**CHECKS PAYABLE TO: PEDRO ARRUZA**

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

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

HIGH SCHOOL: \_\_\_\_\_

YEAR IN SCHOOL (2018-2019)      10<sup>th</sup>    11<sup>th</sup>    12<sup>th</sup>    (CIRCLE ONE)

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

PARENT/GUARDIAN PHONE: (\_\_\_\_\_) \_\_\_\_\_ CELL: (\_\_\_\_\_) \_\_\_\_\_

E-MAIL: \_\_\_\_\_ OFF POS: QB    RB    WR    TE    OL    DEF POS: DL    LB    DB

T-SHIRT SIZE:    M    L    XL    XXL                      EACH PLAYER MUST CIRCLE OFFENSIVE **AND** DEFENSIVE POSITION

**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]: \_\_\_\_\_