

2010 CYCLONE GOLF CAMP REGISTRATION FORM

2010 Cyclone Golf Camp
June 13-17, 2010
Veenker Memorial Golf Course

Resident \$799 ea. _____ x \$799 = _____
Commuter \$699 ea. _____ x \$699 = _____
2-Day \$299 ea. _____ x \$299 = _____
TOTAL _____

Name(s) _____

Address _____

City _____

State _____

Zip _____

Age(s) _____

Grade (next fall) _____

Home Phone () _____

Cell Phone () _____

Fax () _____

Male Female Left Hand Right Hand

Roommate Preference (Camp I) _____

Average Score (for 9 holes) _____

Circle adult T-shirt size: S M L XL XXL

E-mail Address (*will be used to send confirmation packets*) _____

Parent or Guardian _____

Home Phone () _____

Fax () _____



Register online at
www.cyclonegolfcamps.com

Make check payable & return to:

Cyclone Golf Camps
 Iowa State University
 Jacobson Athletic Building
 Ames, IA 50011-1140

Phone: (877) ISU-CAMP or (515) 294-4059

FAX (515) 294-6046

Email jhorton@iastate.edu or martensc@iastate.edu

or

Register online at www.cyclonegolfcamps.com



Permission to use ISU Trademarks is granted under agreement by Iowa State University. The Cyclone Golf Camps is not an Iowa State University Camp but is operated independently.

Release and Medical Authorization

The release and the treatment authorization must be signed by a parent or guardian if student is under 18 years old. Students who are 18 years old or will become 18 years old before the end of the camp/clinic must also sign. In order for students to participate in camp activities, we must have this form prior to the camp's start date. Otherwise, parent or guardian must be contacted prior to release to participate.

Physician's Authorization

This is to certify that this individual was examined by me on _____ (valid if within one year of camp) and that I found this individual to be physically able to participate in vigorous physical and competitive athletic sports. (School physical form acceptable if valid within one year of the starting date of camp.)

Date of physical exam _____ Allergies/Drug sensitivities _____

Other medical problems/current medications _____

Is an identification band or card carried to alert others to the allergy(ies), medical conditions or medication use? Yes No

Signed (Physician) _____ Date _____

Address _____ Office Phone _____

Release of Liability, Medical and Surgical Authorization

In consideration of the Cyclone Golf Camps granting the student permission to participate in Cyclone Golf Camps, I hereby assume all risks of his or her personal injury (including death) that may result from any Cyclone Golf Camps activity. As guardian I do hereby release the Cyclone Golf Camps and their officers, employees, agents, all instructors, and all participants in said Cyclone Golf Camps from all liability, including claims and suits at law or in equity, for injury, fatal, or otherwise which may result from the student taking part in Cyclone Golf Camps activities.

In addition, I hereby authorize and give my consent to the health authorities of Cyclone Golf Camps or any licensed health professional to perform upon or administer any reasonable, necessary surgical or medical treatment. I also give permission to administer whatever anesthetic may be necessary or advisable during the medical or surgical procedures. This authorization is intended to cover emergency treatment, immunizations, injections, and minor operations and procedures. In the case of psychiatric and/or psychological treatment, parent authorization for treatment beyond that responsive to the emergency will be requested. I agree to assume all costs related to such treatment. I authorize my insurance company to pay benefits to Iowa State University Health Service or other hospitals and clinics.

Parent's/Guardian's Signature _____ Date _____

Student's Signature _____ Date _____

Also, I authorize the disclosure of medical information to my insurance company for purpose of claim. I understand that I will be responsible for any medical or other charges in connection with student's attendance at this camp. (Each camper must provide his/her own medical insurance.)

Insurance Information (*please print*)

Name _____

Insurance Company _____

Insurance Co. Address _____

Policy No. _____

Policy Holder _____

Does your insurance carrier require prior approval? Yes No

This form must be returned with your application.