



# Saint Joseph's University Girl's Soccer Clinic

We will come to your club!

**When:** Any Saturday or Sunday or week night for 2 hours.

**Cost:** \$25.00 per player

**Where:** At your designated field

**You must bring:** Water bottle, turfs, cleats, shinguards, and soccer ball

**Who:** Open to all abilities ages 6-14

**Why:**

- Refresh your skills
- Meet SJU coaching staff
- Q & A with current players
- Female Collegiate Players as Role Models
- Small coach to player ratio about 1:7
- Keeper training for those interested.

**Any questions please contact Assistant Women's Soccer Coach Kimmy Pawlowski at 610-660-3367 or email @sju.edu**

*Please complete forms below*

**Please complete and mail along with the check to:**  
**Girl's Soccer Clinic**  
**Attn: Jess Reynolds**  
**Saint Joseph's University**  
**5600 City Avenue**  
**Philadelphia, Pennsylvania 19131-1395**  
*Please make all checks payable to Saint Joseph's*  
*Thanks for your support!*

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Position: \_\_\_\_\_

Soccer Experience: \_\_\_\_\_

\_\_\_\_\_

**Waiver Form**

Since all campers will be under the age of 18, this waiver must be signed by the child's parent or guardian.

**Statement**

I understand Saint Joseph's University, its staff and employees, and the SJU clinic staff are not responsible for any accident or injury occurring to (child) \_\_\_\_\_ while attending camp \_\_\_\_\_.

Parent/Guardian Signature \_\_\_\_\_

Please list any pertinent medical information of which our staff should have knowledge.

\_\_\_\_\_

**Authorization to consent to medical treatment for a minor child**

I, (parent/guardian) \_\_\_\_\_, state that I am the natural parent and/or have legal custody of (child's name) \_\_\_\_\_. I authorize \_\_\_\_\_ head coach and clinic director, to consent to any examination, anesthetic, xray, medical or surgical diagnosis or treatment, and/or hospital care to be rendered to this minor under the general conditions of special supervision and on the advice of any physician or surgeon licensed to practice when efforts to contact me are unsuccessful. This consent form is granted for the period of \_\_\_\_\_.

Parent/ Guardian Name: \_\_\_\_\_

Parent/ Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Emergency Phone Number: \_\_\_\_\_

Medical Insurance Carrier \_\_\_\_\_

Insurance ID # \_\_\_\_\_ Carrier Phone # \_\_\_\_\_