PRIDE SOCCER CLUB

"Doing what's right for kids"

www.pridesoccer.com hward@pridesoccer.com 719-597-6700 ext 206

COMPETITIVE SUMMER CAMPS	**The competitive summer camps are designed to challenge and develop competitive players, and to provide an opportunity to help these players advance their technical, tactical, psychological, and physical levels. The competitive summer camps will focus on improving individual skills as well as increasing the players' understanding of group and team concepts.**
Location:	**Pride Soccer Complex: Woodmen Rd East, 1st right past Marksheffel Rd on Mohawk**
Dates & Registration Deadlines:	**Monday – Friday June 14-18, 2010 (Registration Deadline: June 9)** **Monday – Friday July 26-30, 2010 (Registration Deadline: July 21)**
Camp Information:	**Age** / **Time** / **Price before Deadline** / **Price after Deadline** **U11-U15 (00 teams – 96 teams)** / **11:30am-1:30pm** / **$120.00** / **$140.00**
Payment Information:	**Make checks payable to Pride Soccer and mail to 2660 Vickers Dr. Colorado Springs, CO 80918 or fax to 719.597.4040 with credit card information:**

Player Information: **Age Group: U11 ____ U12 ____ U13 ____ U14 ____ U15 ____**

Camp Selection: **June 14-18, 2010 _____** **July 26-30, 2010 _____**

Name:_____ **Address:** _____ **Zip:** _____

Birth date_____/_____/_____ **Gender:** ____ **Home Phone:**_____ **Work:**_____ **Cell:** _____

Email: *

2nd email:

*writing in your email constitutes permission for us to contact you. We do not sell or give out email addresses. All announcements are done through email. Please give us all addresses that will be checked daily.

Team Information: **Team Name:** _____ **Coach:** _____

Consent for Emergency Medical Treatment and Permission to Play:
The undersigned gives consent for my child to participate in Pride Soccer Camps. I further agree to hold Pride Soccer Camps, coaches and managers harmless for all claims or actions due to personal, property or injury, which may result from my child's participation. In the event I cannot be reached, I hereby give permission to the physician selected to seek treatment for my child.

Parent's Signature: _____ Date: _____

Credit Card Information: **O Visa O MasterCard O Discover O Am Express**

Act #_____ Exp _____ Security Code: _____

For Office Use:
Amount _____ Chk#_____ Ap#_____ Reg#_____ Date_____ Initials _____