PRIDE SOCCER CLUB

"Doing what's right for kids"

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

Predators Skills and Fitness Camp	**The Predators camps are designed to challenge and develop the elite player, and to provide a training environment intended to help the player compete at a higher level. The Predators camps will focus on improving individual technique and developing more advanced skills. As well as improve the player's ability to perform at a faster game speed, and to increase their overall game fitness so the player can maintain a high level of play in a state of fatigue.**
Location:	**Pride Soccer Complex: Woodmen Rd East, 1st right past Marksheffel Rd on Mohawk**
Dates & Registration Deadlines:	**Mon – Fri June 7-11, 2010 and July 19-23, 2010 (Registration Deadline: June 4 and July 16)**
Camp Information:	**Age: U11-U15 (Pred 00 – Pred 96) | Time: 9:00-11:00am | Price before Deadline: $150.00 | Price after Deadline: $170.00**
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 Pred 00 ____ U12 Pred 99 ____ U13 Pred 98____ U14 Pred 97 ____ U15 Pred 96 ____**

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 _____