

**Victory Sports Camp**  
**July 18-22, 2022**  
**9:00 a.m. – 4:00 p.m.**  
**Cost: FREE**

Sponsored by Chesterfield County Churches



Venue: Lower Macedonia Baptist Church  
5267 Teals Mill Rd, Chesterfield, SC  
Sports-9am-noon/VBS:1pm-4  
lunch provided

Grade Completed: \_\_\_\_\_

Child's Name: \_\_\_\_\_

M F Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ All children who have completed grades 1 - 6 are eligible.

Parents' names: \_\_\_\_\_

Address: \_\_\_\_\_

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

Parents/Guardian Phone: (h) \_\_\_\_\_ (cell) \_\_\_\_\_

Email address: \_\_\_\_\_

Sport choice (circle one: unable to switch sports once camp begins):

Football Baseball Softball Basketball Cheer Volleyball Soccer

T-shirt Size: YS \_\_\_\_\_ YM \_\_\_\_\_ YL \_\_\_\_\_ AS \_\_\_\_\_ AM \_\_\_\_\_ AL \_\_\_\_\_ AXL \_\_\_\_\_

\*\*\*Known Allergies & Health Concerns: \_\_\_\_\_

Do you currently attend a local church? YES NO

I/we authorize the VSO or its designees, to create, have and use photographs, slides, and videos containing my child's image for its record keeping or marketing/public relations programs. YES NO

**PARENT/GUARDIAN OF A MINOR CONSENT & HOLD HARMLESS/ PERMISSION TO TREAT INFORMATION**

I, \_\_\_\_\_, being the parent/legal guardian of \_\_\_\_\_ have been informed of the above activity sponsored by Victory Sports Outreach, Inc. and Chesterfield County area churches hereby give my consent for my minor child to participate in this activity.

I understand that all reasonable safety precautions will be taken by the leaders of this activity, and that the possibility of an unforeseen hazard does exist. I further agree not to hold *Victory Sports Outreach, Inc., Lower Macedonia Baptist Church and sponsored churches*, its leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries by the minor listed on this form.

I do consent to any medical treatment that may be deemed necessary for my minor child. Further, I understand that all efforts will be made to contact me prior to treatment. In the event I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child. I further understand that the doctors, dentists, and other providers attending to my child will take all reasonable safety precautions during their care.

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

Parent/Guardian (Printed Name): \_\_\_\_\_

**Contact Information:**

Lisa Robson: email- mlvrobson@gmail.com