



# Coach Tegean

**Dates: July 8 – 12, 2019**

**Time: 8:30am - 12Noon (Drop off available at 8:00 am.)**

## KVA Soccer Camp

**Ages: Rising K5 through Rising 8<sup>th</sup> Graders**

**Location: Kerr-Vance Academy, Soccer Field**

**Cost: \$100**

Checks made out to Kerr-Vance Academy

**Time 6:00 pm-7:30 pm Ages: Rising 9<sup>th</sup>-12<sup>th</sup> Graders**

### Camp Information

If you've never played soccer, or if you play every day, this is the camp for you. The important thing is to get started while you're young so that you won't miss a day of the fun that soccer can be. This is the place for all young players to receive great individual instruction from a proven winner.

Experience a week of camp which has as its mission to teach fundamentals of soccer through team competition, group instruction and individual attention. Coach Tegean is a varsity coach and a KVA parent.

Participants are encouraged to have shin guards and their own soccer ball. This allows for personal drills and instruction.

**SOCCKER BALL SIZES (this is important)**

Ages 5-7 ball size 3

Ages 8-11 ball size 4

Ages 12 and up ball size 5



## Camp Registration Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parents/Guardians: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone (Mom): \_\_\_\_\_ Work Phone (Dad): \_\_\_\_\_

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

Camper's Current School and Grade: \_\_\_\_\_

### Medical Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Please note any health problem, physical handicap, emotional difficulty, behavioral problem, or facts which may limit full participation: \_\_\_\_\_

Camper is subject to:

asthma   fainting   sensitive skin   sinus trouble   bee stings/insect bites   bronchitis  
nosebleed   allergies (describe)   Headaches   Nausea   Heat Sensitivity Other

Camper wears contact lenses: Yes   No

Medications: List any medications your child is currently taking.

Name of medication(s): \_\_\_\_\_

Purpose of Medication: \_\_\_\_\_

In case of emergency, I hereby give permission to the physician selected by the Coach to provide necessary treatment for my child.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Information for questions and information:

Kerr-Vance Academy  
252-492-0018  
Email: Alison Short  
[ashort@kerrvance.com](mailto:ashort@kerrvance.com)