



# 2019 Summer Camps

## FUTURE CAMP

June 19, 2019  
9:00 am – 1:00 p.m.  
\$45.00

**8 or more players from the same organization - \$30 per player**

Join the Zips for a morning of summer softball.

Hit, field, base run, pitch and catch – work on your position or learn a new one!  
Designed for kids 6 – 11 years of age. Participants will be divided by age/skill level.

Check in at Lee Jackson Softball Field from 8:30 – 8:45 am.  
For more information, email Coach Pratt at [jpratt@uakron.edu](mailto:jpratt@uakron.edu)

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### ZIPS FUTURE ZIPS CLINIC REGISTRATION

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

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

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Team name: \_\_\_\_\_ Age level of team: \_\_\_\_\_

#### Emergency Medical Authorization

I am aware of the risks, hazards and inherent dangers that may arise due to my child's participation in the 2019 Future Zips Camp being held at The University of Akron (collectively referred to as "UNIVERSITY") on June 19, 2019.

In consideration for being allowed to participate in said activity, I hereby release, waive and discharge UNIVERSITY, its instructors, agents and employees from every claim, liability or demand of any kind sustained, whether caused by the negligence of the UNIVERSITY or otherwise. This release shall be binding upon any heirs, administrators, executors and assigns of mine. I further agree to indemnify the UNIVERSITY from any loss, liability, damage or cost it may incur due to my participation in said activity in any way whether caused by the UNIVERSITY or otherwise.

In the event of illness or injury resulting or arising directly or indirectly out of said activity, I hereby give my consent and authorization for (1) the administration of emergency first aid care and treatment at the scene of an emergency by faculty, staff members or volunteers of UNIVERSITY or (2) the administration of any treatment deemed necessary by a licensed physician or dentist and (3) the transfer to any hospital reasonably accessible. This authorization is not intended to cover major surgery unless the medical opinions of two (2) licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

I further declare and warrant that I am covered by sufficient medical and dental insurance and that such insurance will remain in effect during my child's participation in said activity.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

**Return application and payment to: Akron Softball, The University of Akron, 297B Athletics Field House, Akron, OH 44325**