

*Please make checks payable to:*  
**Rehabilitation and Sports Medicine**  
125 Hospital Drive, Watertown, WI 53098  
*Please call Watertown Area Health Services Sports Medicine with any questions*  
262-4220

Name \_\_\_\_\_  
Phone \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_  
Sports \_\_\_\_\_

T - shirt size:      Small    Medium    Large    XLarge

School \_\_\_\_\_ Amount Enclosed \_\_\_\_\_

## INFORMED CONSENT

I understand my son/daughter will be participating in the WAHS Sports Medicine Speed and Agility Camp. This camp will be held on Mondays, Wednesdays, and Fridays for 6 weeks starting on June 12th 2006.

The goals of this program is to improve athletic performance, prevent future injury and to have fun. I understand with this program there is a risk of injury. Serious injury can result from physical activities, and in extreme cases could cause death.

I, \_\_\_\_\_, will allow my son/daughter to participate in the Watertown Area Health Services Sports Medicine's Speed and Agility Camp. I understand the inherent risks involved and will not hold Watertown Memorial Hospital or Watertown Park and Recreation Department responsible for any injuries which may occur to my son/daughter.

Parent/Guardian Name

\_\_\_\_\_

Parent/Guardian Signature

\_\_\_\_\_

**Please complete and mail in registration form by June 1, 2006**  
**PLEASE NOTE: Registration is limited to ensure a low participant to instructor ratio**