ALL-PRO
LINEMAN CAMP, LLC.

"It all starts in the Trenches"

All-Pro Lineman Camp LLC is for High School players, ages 14 to18

Name _________________________ Height _______ Weight ________ Grade in Fall _____ Age _____

Address ______________________________ City ____________________ State ______Zip_________

Parents Name _______________________________________ Home Phone (______)______-_________

Work Phone (______)______-________ Cell Phone (______)______-_________

Emergency Contact _________________________________ Phone (______)______-_________

High School Attended ____________________________ Coaches Name__________________________

I, _______________________________ give my son permission to attend the ALL-PRO Lineman Camp, LLC. I certify that within the last two years, he has had a physical examination and that now he is physically able to participate in the ALL-PRO Football Camp activities without restriction. In the event of an illness or injury, I give my consent for medical treatment and permission to the attending physician to hospitalize, secure proper treatment, and order injections, anesthesia, or surgery. I will be responsible for any medical or other charges in connection with my son's attendance in camp not covered by the insurance policy of the camp. I acknowledge that the ALL-PRO Lineman Camp, LLC my son will participate in is a sport camp, which may involve, among other things, physical contact of the body with other persons or objects, including the ground and that at the ALL-PRO Camp; he may incur a risk of injury. I specifically waive, give up any claim for personal damages, which I, or my son may have for injuries or illness that he sustained at the camp. I further authorize the ALL-PRO Lineman Camp LLC to use my son's name, photographs of my son and or articles about my son for publicity purposes.

I will be bringing my own helmet and shoulder pads (Please Circle) YES or NO

History of Asthma (Please Circle) YES or NO

IF Yes to asthma, I will be bringing and using an Inhaler (Please Circle) YES or NO

History of Seizures (Please Circle) YES or NO

History of Concussions (Please Circle) YES or NO

Insurance Company: _______________________________________ Policy #_____________________

Signature of Parent or Legal Guardian ___________________________________ Date____/____/____

FOR OFFICE USE ONLY

Check No. ________ Amount __________ Date Received: ____/____/____