




## MEN'S SOCCER

83 Windham Street

Willimantic, CT 06226

**LITTLE EAST CHAMPIONS 2007\*2009**



Greg DeVito, Head Coach

Adam Phaiah, Assistant Coach

devitog@easternct.edu 860-465-4334

**NCAA TOURNAMENT 2007\*2009 \*2010**

## HIGH SCHOOL SOCCER CLINIC

Date: December 11, 2011  
Place: Eastern Connecticut State University  
Time: Registration: 9:30am Clinic: 10am-4pm  
Ages: 10<sup>th</sup> to 12<sup>th</sup> graders  
Tuition: \$100

Tuition includes:

- Guided campus tour
- Lunch
- 2 training sessions that will be coached by Eastern Connecticut State University staff.
- Small sided and or large sided match that will be coached by Eastern Connecticut State University staff
- Presentation from Admissions Office
- T-Shirt

**Space is limited—Call to reserve your spot**

Return the form below with payment made payable to: ECSU Foundation  
Mail To: Greg DeVito Men's Soccer Office, 83 Windham Street Willimantic, CT 06226  
Please call with questions: 860-465-4334  
Mail By: December 1, 2011 or RSVP to let us know that you are planning on attending

Name \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ Shirt Size M L XL

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade (Fall 2011) \_\_\_\_\_

I certify that the applicant is in excellent physical health and is capable of participating in a strenuous activity, to with soccer. I further certify that I give my permission to him/her to participate in the soccer and fitness training being conducted by Greg DeVito, and Staff. I also agree to hold harmless the directors as stated above, ECSU, it's staff, agents, host site and employees from any and all injuries sustained by the participant during his/her participation in the soccer and fitness training. In case of emergency, I grant permission for the applicant to be given treatment at a local hospital. Any expense arising from injury or illness is the responsibility of parental insurance coverage. I have read and fully understand this release statement.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Policy #: \_\_\_\_\_ Social Security Number of Insured: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_