

# CAPON RIDGE CROSS COUNTRY CAMP 2020 REGISTRATION INFORMATION

Name \_\_\_\_\_

Address \_\_\_\_\_

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

Phone \_\_\_\_\_ Email Address \_\_\_\_\_

High School \_\_\_\_\_ Grade (Fall '20) \_\_\_\_\_

Gender: Male Female      T-Shirt Size: XS S M L XL

Parent Name \_\_\_\_\_

Parent Email \_\_\_\_\_

## Camp Pricing

**\$500** through April 15, 2020 | **\$550** April 16, 2020 through sell out

*After May 1, a \$100 processing fee will be applied to all refunds. No refunds after June 30, 2020.*

*Cost includes lodging, 3 meals per day, a camp t-shirt, as well as coaching, speakers, video analysis & more.*

## Make checks payable to PR Training Programs LLC

### RETURN REGISTRATION FORM TO:

Capon Ridge Running Camp  
12818 Kettering Drive  
Herndon, VA 20171

**All information is required in order to process this application.** You must send proof of medical insurance with application (**a photocopy of the front and back of the campers medical insurance card is required**). Please do not bring valuables, electronics or large sums of money. The camp will not be responsible for lost or stolen items.

**For additional information: [mike@potomacriverrunning.com](mailto:mike@potomacriverrunning.com) or call 703.209.3585**

#### Waiver/Medical Consent:

I hereby state that my child is in good normal health, and has my permission to participate in all camp activities. In the event of injury or illness, I authorize the staff of Capon Ridge Running Camp to act for me in securing medical treatment. Registration in Capon Ridge Running Camp requires that a parent/guardian sign below to agree that in case of accident or injury while attending camp, they release the camp, the coaches, counselors, Potomac River Running, Inc. and any associated parties from any and all liability. Further, I grant permission to all the foregoing to use any photographs, motion pictures, recordings, or any other record of this event for legitimate purposes. Each participant is required to carry personal medical coverage.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date