

***IF YOU REGISTER ONLINE, YOU MUST STILL  
PRINT THE APPLICATION, FILL IT OUT  
(IN FULL) AND MAIL IT IN***

COMPLETE THE ENTIRE THREE PAGE FORM

Make Checks Payable to **Pin2Win, Inc.**

Mail the completed application to:

Pin2Win, Inc.  
c/o Gene Mills  
4024 Pinyon Pine Path  
Liverpool, NY 13090-1114

**NON-REFUNDABLE DEPOSIT FOR WRESTLING CAMP OF  
\$125.00 MUST ACCOMPANY APPLICATION TO SECURE  
REGISTRATION.**

Balance due at registration.  
It is not necessary to include this cover sheet when you mail in your  
application.

**Get ready to Learn, Work, & Have Some Fun**

**2009 WORLD SILVER MEDALIST JAKE HERBERT**

Wrestling with Gene Mills, Screwy Louie Lazzari, NCAA Champions  
Damion Hahn, Matt Valenti and Olympian Carmelo Flores, Veterans  
World Place-Winner Tim Boda, Two time All-American Matt Oney, and  
many other great coaches.

We look forward to seeing you at camp.

Directions, Map, and What to Bring are on this website.

# GENE MILLS CAMPS

<input type="checkbox"/> July 11-15, 2010 - Technique & Intensive Camp	<input type="checkbox"/> July 18-22, 2010 - Technique and Competition Camp
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## PERSONAL INFORMATION

Name <i>(Last, First, M.I.)</i>		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date	Age	Grad Year
Address		City		State	Zip
Phone	Email Address <i>(We will email confirmation and balance information)</i>			T-Shirt Size <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> XL	
Group of 8 or more? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of Team or Group	Please provide name and contact number for group			Approx Weight
Is a coach attending camp with your team/group? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Coaches Name			If Yes, Coaches Phone	

## EMERGENCY CONTACT INFORMATION

Primary Emergency Contact	Phone
Secondary Emergency Contact	Phone

## MEDICAL INSURANCE

**\* Please provide a copy of your Insurance Card**

Is participant covered by family medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Carrier/Plan Name		Group Number	
Carrier Address	City	State	Zip Code
Name of Insured	ID Number	Relationship	
Is pre-approval required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Telephone Number for Pre-Approval		

## PERSONAL HEALTH HISTORY

<b>Health History:</b>	<input type="checkbox"/> Asthma <input type="checkbox"/> Ear Infections <input type="checkbox"/> Migraines <input type="checkbox"/> Convulsions <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Murmur		
<b>Allergies:</b>	<input type="checkbox"/> Bee Stings <input type="checkbox"/> Hay Fever <input type="checkbox"/> Food <input type="checkbox"/> Penicillin <input type="checkbox"/> Other Drugs: _____ <input type="checkbox"/> Other: _____		
<b>Immunizations and dates:</b> <i>(Month and Year)</i>  <b>REQUIRED!</b>	<input type="checkbox"/> DTP Series		<input type="checkbox"/> Tuberculin Test (TB)
	<input type="checkbox"/> Tetanus/Diphtheria		<input type="checkbox"/> Haemophilus Influenza B
	<input type="checkbox"/> Tetanus		<input type="checkbox"/> Hepatitis B
	<input type="checkbox"/> Rubella		<input type="checkbox"/> Varicella/Chicken Pox
	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>		<input type="checkbox"/> Booster
			<input type="checkbox"/> Meningitis

## OPERATIONS OR SERIOUS INJURIES

Date	Condition	<i>If NO operations or serious injuries, check here: <input type="checkbox"/></i>

## CHRONIC, RECURRING ILLNESS, OR SERIOUS ILLNESS IN THE LAST SIX MONTHS

*Note: All Surgeries, serious conditions, or illnesses require a physicians clearance prior to attending camp*

When	Recurring/Serious Illness	<i>If NO Chronic, Recurring, or Serious Illness, check here: <input type="checkbox"/></i>

# GENE MILLS CAMPS

## MEDICATIONS BEING TAKEN

Please list all medications (including over-the-counter) taken routinely. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

Name of Drug	Dosage	Frequency Taken

Reason for Taking

*If you are taking NO medications, check here:*

*Please Note: We are unable to administer any over-the-counter medications i.e. Tylenol, Advil, etc.  
If you feel there may be a need for these, please bring your own.*

## RESTRICTIONS/LIMITATIONS WHILE AT THIS CAMP (PLEASE BE SPECIFIC)

*If you have NO restrictions or Limitations, check here:*

## ANY ADDITIONAL HEALTH INFORMATION THE CAMP SHOULD BE AWARE OF

*Important: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance. This includes any skin disorders such as ringworm. If there is NO additional health information the camp should be aware of, check here:*

## ADDITIONAL CONDITIONS

*Important: Campers with the following conditions must provide written physician's clearance before attending camp. Please return an official letter of physician's clearance for each item checked.*

- |  |   |
|--|---|
| <input type="checkbox"/> Fracture in the last 6 months       | <input type="checkbox"/> Surgery in the past year             |
| <input type="checkbox"/> Heart Condition (Including murmurs) | <input type="checkbox"/> Spinal Injury or Head Injury         |
| <input type="checkbox"/> Seizure Disorder                    | <input type="checkbox"/> Loss of Organ                        |
| <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Hemophilia                           |
|  | <input type="checkbox"/> Hospitalization in the last 6 months |

## FAMILY PHYSICIAN

Name	Address
Telephone Number	

## PARENT/GUARDIAN AUTHORIZATION

**This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permissions to the certified athletic trainer to provide routine health care, administer prescribed medications and seek emergency medical treatment, including ordering X-rays for routine tests.**

**I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above.**

**I agree to assume full responsibility for any damages to property and person as a result of my child's actions while at camp. I further agree to reimburse the host facility for damages. I hereby wave and release Pin2Win, Inc. and the host facility from any and all liability for any injuries incurred by my child while attending camp.**

**I recognize that there are inherent dangers in the sport of wrestling and its training elements.  
I agree to assume all risks related to my child's participation.**

Print Name

Signature

Date

For Office Use Only

Deposit	Check Number	Amount
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**MENINGITIS RELEASE**

*In Accordance With NY State Law:*

**Meningococcal Meningitis is a bacterial illness affecting the brain. It can be spread by cough, sneeze, kiss, sharing drinks, or by any other direct contact or airborne means of transportation. Therefore, campers residing in small areas, such as cabins, are at an increased risk for contracting the illness.**

**The signs and symptoms of meningococcal meningitis are similar to the common flu often making it hard to detect. The signs and symptoms include the following: high fever, nausea, vomiting, fatigue, headache, stiff neck/back, skin rashes and confusion. Frequently, not all signs are symptoms occur, and the illness may progress rapidly. Treatment of meningitis is antibiotic therapy.**

**A vaccination is available, and is an effective way to help prevent meningococcal meningitis, although any vaccine is not an absolute guarantee. There are rarely side effects associated with this vaccination. Pin2Win camps will not provide the meningitis vaccine. Contact your family care provider for information regarding availability and associated costs of the vaccination.**

**I, the parent or legal guardian have received, reviewed, and understand the above information regarding meningococcal meningitis and my son/daughter has either received the immunization with 10 years preceding or has elected not to obtain the immunization against meningococcal meningitis.**

Print Name

Signature

Date

Camper Referred By:

Where did you hear about Gene Mills Pin2Win Wrestling Camps?

**PIN2WIN INC. HOLD HARMLESS AGREEMENT**

1. I give permission for my child to go swimming in the camp pool. \_\_\_\_\_ (Initial if permitting)
2. I am aware of the inherent dangers and risk involved in sports camps, including, but not limited to bodily injury or death.
3. I understand that due to the nature of wrestling, contagious skin infections may occur. I agree that my child is responsible for personal hygiene, including showering after each session and washing with soap (we will provide soap, if needed). Furthermore, I agree that my child must report any skin infection to the camp medical staff for diagnosis, and to help prevent its' spread as a result of body to body contact. I understand that in the event of a skin infection, my child will not be permitted to physically participate in wrestling sessions until free of all contagious infections and that observing sessions constitutes a learning experience. I agree that no refund will be issued if my child remains at camp and does not participate due to an infection.
4. In the event of an injury or illness, I give permission for my child to be treated by a certified athletic trainer or seek emergency medical treatment and transportation to an area hospital or medical center. I also give permission to the athletic trainer to administer any medications indicated on medical form.
5. I understand that Pin2Win Inc, or host facility, does not provide any accident or medical insurance and that I am required to provide it for my child. I do so under the policy listed below and, I agree that I am financially responsible for any and all medical expenses associated with my child's participation in this program. Please provide insurance provider and policy number on health form.
6. I agree, on behalf of myself, my child, and our assigns, executors, and heirs to indemnify, and hold harmless, Pin2Win, Inc., Gene Mills, and employees from any and all liability, damage and claims of any nature arising out of or in any way related to my child's participation in this camp except for those caused by the sole negligence of Pin2Win, Inc.
7. I understand that Pin2Win, Inc. is not responsible for lost or stolen items. Please do not bring valuables to camp.

Print Name

Signature (Parent or Guardian)

Date