

QUEST SOCCER YOUTH CAMPS

COMMITMENT TO EXCELLENCE

GOLDEN GOAL CAMP

WHO: Boys and Girls
Ages: K - Entering 7th gr
WHERE: Jackson N. Park
WHEN: Mon Jun 24th - Thur Jun 27th
TIME: 9:30 – noon
COST: \$85.00

CAMP DIRECTOR

Frank Gagliardi
30 yrs of youth coaching &
camp directing
former Canton Invader of NPSL
Jackson HS Girls Coach 27 yrs.
captain, MVP & All-conference
player for Ohio Northern University

Please complete & return your camp
registration & payment to:

Frank Gagliardi
6585 Hythe Street NW
Canton, OH 44708

Camp Name: _____

Location: _____

Name of Camper : _____

AGE _____ **DOB** _____ **Grade** _____

Address: _____

School: _____

Emergency Phone _____

SHOOTING STARS CAMP

WHO: GIRLS ONLY
Ages K – Entering 7th gr
WHERE: Jackson N. Park
WHEN: Mon Jul 8th- Thurs Jul 11th
TIME: 5:30 – 8:00PM
COST: \$90.00

CAMP STAFF

Members of the Jackson Girls Soccer Team
Current and former College Players

DRILLS AND TOPICS COVERED
Speed and Agility Training
Dribbling & Foot skills
Passing & 1ST Touch
Shooting
Heading
Small Group Tactics

*We guarantee you that the staff at the Quest
Soccer Camp will do everything it can to
ensure you an environment conducive to
learning soccer and having a great time!*

****Second Family member \$10 off at same camp****

Camp flyers were paid for by Quest – Staff is FBI background checked

MEDICAL RELEASE FORM

I certify that my child enrolled above is in excellent health
and may participate in strenuous physical activities
including soccer. I agree to defend and hold the coaches
of the Quest Soccer Camp, U.S. Club Soccer, Jackson
Fury soccer club, and all their servants, agents, and/or
employees and contractors harmless from any and all
claims for injuries sustained by my child during his/her
participation in the camp. Permission is granted for my
child to receive emergency medical treatment, if needed.
I certify that there are no limits to my child's participation
except as stated in writing and included with this
application.

Consenting Parent's/Guardian's Signature:

Address: _____

Physician's name: _____

Hospital: _____

Medical History: _____