Print Reset

California State University: Stanislaus

CAMP/CLINIC PARTICIPANT ROSTER

Camp/Clinic Name	
Date	
Coach/Director	
Total # of Participants	
Total # of Adult Staff	

			Date of ATTENDANCE					
Participant LAST Name	Participant FIRST Name	Particpant AGE						
Adult Supervisors								
LAST Name	FIRST Name							

RETURN A COPY OF THIS ROSTER TO THE SAFETY AND RISK MANAGEMENT OFFICE WITHIN FIVE DAYS OF THE CAMP END DATE

FAX: 209-667-3104 OR EMAIL: risk@csustan.edu

			Date of ATTENDANCE					
Participant LAST Name	Participant FIRST Name	Particpant AGE						
Adult Supervisors LAST Name	FIRST Name							

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