

California State University: Stanislaus  
**CAMP/CLINIC PARTICIPANT ROSTER**

Camp/Clinic Name								
Date								
Coach/Director								
Total # of Participants								
Total # of Adult Staff								
			<b>Date of ATTENDANCE</b>					
Participant LAST Name	Participant FIRST Name	Participant AGE						
<b>Adult Supervisors</b>								
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](mailto:risk@csustan.edu)

Participant LAST Name	Participant FIRST Name	Participant AGE	Date of ATTENDANCE					
<b>Adult Supervisors</b>								
LAST Name	FIRST Name							

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