

# Celtic Youth Lacrosse Summer Camp

Dublin Jerome High School Turf

June 8-June 11 1-3:30pm

Girls grades 1<sup>st</sup> through 6<sup>th</sup>

\$100 payable to DJHS LAX BOOSTERS

\$125 after June 1 (sorry no refunds)

Basic skill instruction will feature individual, team, offense and defense.

**Girls must have goggles, sticks and mouthguards to participate**

Questions call Colleen Bender: 560-6786 or email

bender\_colleen@mail.dublin.k12.oh.us

Please Detach and mail to Youth Lax Camp 5584 Rainbow Falls St Dublin Oh 43016

Name: \_\_\_\_\_ Grade/School \_\_\_\_\_

Address: \_\_\_\_\_ City/ Zip \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Email address: \_\_\_\_\_ T-shirt Size: **XS, S, M, L**

Liability Waiver-Dublin Jerome or their representatives cannot and will not be held liable for any injuries incurred while involved at the Dublin Youth Lacrosse Camp.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PARENTAL CONSENT FOR EMERGENCY MEDICAL TREATMENT

**Please PRINT all information.**

Name of Player: \_\_\_\_\_

Name of Parent or guardian: \_\_\_\_\_

If parents are not available, please call relative below:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

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

Health Insurance Information:

Company Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Address: City/State/Zip: \_\_\_\_\_

**\*\*\*A COPY OF YOUR INSURANCE CARD MUST BE ATTACHED TO THIS FORM\*\*\***

Past injuries/illnesses that affected participation & dates: \_\_\_\_\_

Special medical or health conditions: \_\_\_\_\_

Food or drug allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

*IN CASE OF EMERGENCY, I UNDERSTAND THAT EVERY EFFORT WILL BE MADE TO CONTACT ME. IF I CANNOT BE REACHED, I HEREBY GIVE PERMISSION FOR AN ADULT COACH OR CHAPERONE TO ACT IN MY BEHALF IN SEEKING EMERGENCY TREATMENT FOR MY CHILD IN THE EVENT THAT SUCH TREATMENT IS DEEMED NECESSARY. I GIVE PERMISSION TO THOSE ADMINISTERING EMERGENCY TREATMENT TO DO SO, USING THOSE MEASURES DEEMED NECESSARY. I ABSOLVE SAID PARTY FROM LIABILITY IN ACTING ON MY BEHALF IN THIS REGARD.*

Parent Signature: \_\_\_\_\_

Address: \_\_\_\_\_

City/St/Zip: \_\_\_\_\_

Date: \_\_\_\_\_