WKHS Field Hockey TEAM CAMP 2022!

When: July 18th-21st, 9am to 12pm
Where: Worthington Kilbourne HS Stadium Turf
Cost: $95 Payable to WKHS Field Hockey Boosters
Check or Venmo @WKHS-FieldHockey
Staff: WKHS Coaches and college players
Players bring: shin guards, mouth guards, sticks, protective goggles & water
Who: Open to any and all incoming and HS players

Basic skills, full game tactics and small group games will be covered at camp.

"Just play, have fun and enjoy the game" - Michael Jordan

Player Name: ______________________ Grade (fall 2022): _____
Parent Names: ____
Parent Emails: ____
Parent Phone #s: ____

REGISTRATION DUE BY: July 8, 2022

Return Registration Form and Payment to:

Coach Alexandra Street, 9447 Wilbrook Dr Powell, OH 43065

Questions: astreet813@gmail.com or cell: 614-565-6967

WKHS 2022 Team Camp

Parental/Guardian Consent and Waiver

I hereby give my consent for my daughter

____

to attend the 2022 WKHS Team Camp 7/18/22 – 7/21/22. I hereby release and discharge Alexandra Street, Worthington City Schools, Worthington Kilbourne High School, the facilities at the Worthington Kilbourne High School turf field, any coach, and all employees of any injuries or illnesses which may result because of participation in the team camp. By signing this form, you, on behalf of yourself and your daughter or any other persons for whom you are legal guardian, confirm: (1) That you understand the statements contained on this form; and (2) That you release Alexandra Street, any employees or volunteers of the camp, and Worthington City Schools for any claims, liability, injury or damages occurring during this team camp.

____

Parent or Guardian Date

(COMPLETE MEDICAL AUTHORIZATION ON NEXT PAGE!)

2022 WKHS TEAM CAMP

EMERGENCY MEDICAL AUTHORIZATION PART 1 OR 2 MUST BE COMPLETED

Please PRINT

Player's Name: ____

PART 1 (TO GRANT CONSENT)

In the event reasonable attempts to contact me at ________________________ or at ___________________ have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary
by Dr. _________________________ at _________________________ or

(preferred physician)
by Dr. _________________________ at _________________________ or

(preferred dentist)
in the event the designated preferred practitioner is not available, by another licensed physician or dentist and (2) transfer of my child to

____
or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in necessity for such surgery, are obtained before surgery is performed.

Signature of Parent/Legal Guardian Date:

____

Known Allergies: Current Medications:

____

Health Concerns (Diabetes, Asthma, Bee Stings, Etc.)

____

Physical Impairments: ____

Date of Last Tetanus Booster: ______________________________________

* *

PART 2 (REFUSAL TO CONSENT) DO NOT COMPLETE PART 2 IF YOU COMPLETED PART 1: I do not give my consent for emergency medical treatment of my child, in the event of illness or injury requiring emergency treatment, I wish the school authorities to TAKE NO ACTION OR TO:________________________________

____

Signature of Parent/Legal Guardian & Date____________________________________