

WKHS Field Hockey Youth Camp 2022

When: June 20th-23rd, 9am-11:30am

Where: Worthington Kilbourne HS Stadium Turf

Who: Grades 2-8 (no experience needed)

Cost: \$95 Payable to WKHS Field Hockey Boosters
Check or Venmo @WKHS-FieldHockey

Staff: WKHS Coaches and WKHS players

Players bring: shin guards, mouth guards, sticks, protective goggles & water

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: June 1, 2022

Return Registration Form 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 _____