HARTLEY Field Hockey Camp

YOUTH CAMP DATES/TIMES/LOCATION

Dates: Tuesday, July 23 - Thursday, July 25
Time: 9:00 am – 11:30 am
Location: Bishop Hartley High School, Jack Ryan Field

CAMP COST

Youth Camp $65; please make checks payable to ***Bishop Hartley High School***
Cost assistance is available if needed, contact Bridget Ebenhack (614) 394-3413.
Refund policy - a full refund, minus a $15 cancellation fee, will be issued for cancellation prior to camp. No refunds will be issued once camp begins regardless of the reason.

CAMP GOALS

The Youth Field Hockey Camp is designed to introduce young athletes to the fundamentals of field hockey. The focus will be on basic skills and techniques, as well as game play. Our hope is to help student athletes develop lifelong team skills and lessons in a fun, supportive environment.

ELIGIBILITY

The Field Hockey Youth Camp is open to any athlete entering 4th – 9th grade. This camp is suitable for athletes of all experience and ability levels.

REGISTRATION INFORMATION

The registration deadline is July 10, 2019. After the deadline, please contact Bridget Ebenhack at (614) 394-3413 or bridgetebenhack@hotmail.com. Campers must pay in full at the time of registration. To register by mail, complete the camp application and mail to:

Bishop Hartley High School
Field Hockey Camp
1285 Zettler Rd.
Columbus, OH 43227

ADDITIONAL INFORMATION

Contact Bridget Ebenhack (614) 394-3413; bridgetebenhack@hotmail.com

Application Form

Camper's Name: _____ Grade (Fall 19) _____

Address _____

City _____ State _____ Zip _____ School

_____

Email(s) _____

Contact Person _____Relation _____ Phone _____

Camper T-Shirt Size: _____ YS _____ S _____ YM _____ YL _____ YXL_____ S_____ M_____ L_____ XL

EMERGENCY MEDICAL FORM

The purpose of this form is to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under our authority, when parents or guardians cannot be reached.

RESIDENTIAL PARENT OR GUARDIAN _____

Mother's Name_____

Daytime Phone (_____) _____

Father's Name_____

Daytime Phone (_____) _____

Name of Relative or Childcare Provider_____

Relationship_____ Daytime Phone (_____) _____

Address_____

I hereby give consent for the following medical care providers and local hospital to be called:
DOCTOR_____ PHONE (_____) _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent of (1) the administration of any treatment deemed necessary by the above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted, I have listed below.

_____

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SIGNATURE OF PARENT / GUARDIAN_____DATE _____