Date Received: _____

Paid: _____

2012 Fall Youth Boys Lacrosse Clinic Registration Form

Hosted by UHS Boys Lacrosse Boosters

Taught by UHS Varsity Head coach John Rohde and Varsity Lacrosse players

Unionville Community Fairgrounds – Saturday, October 6TH 12:30-2:30pm

$20/player PLUS food donation to Chester County Food Bank

EACH ENTRANT RECEIVES 1 FREE TICKET FOR THE GOLF BALL DROP TO BE HELD AT THE CONCLUSION OF THE CLINIC!

Grade in Fall 2012: 1st 2nd 3rd 4th 5th 6th 7th (Circle one)

Player Information:

[We ask that you please fill out ***all*** information in this section]

Name: _____

Address: _____

City: _____ State: ___ Zip: _____ Home Phone: _____

Date of Birth: _____

Known Allergies _____

Current Medication _____

School Attending ***Fall 2012*** _____

Position: Circle all that apply - Midfield Attack Defense Goalie

Parent/Guardian Information:

Mother's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
(if different from player)
Home/Cell Phone: _____

Father's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
(if different from player)
Home/Cell Phone: _____

Email address(es): Primary form of communication for schedule changes/cancellations
Please note: your privacy is important to us, e-mail address(es) are **NOT** shared with others.

_____ _____

Emergency Contact Information:

Name: _____ Phone: _____ Relation:_____

Any medical conditions? _____

_____

Insurance Carrier: _____ **Member id:** _____

***Parents, please note:**
My child and I/we are aware that participating in this clinic is a potentially hazardous activity. I/we assume all risks associated with participation in this sport, including but not limited to falls, contact with other participants, the effects of the weather, traffic, and other reasonable risk conditions associated with the sport. All such risks to my child are known and appreciated by me. I/we understand this informed consent form and agree to its conditions on behalf of my child. In case of an emergency accident or injury, I/we authorize the clinic staff to provide emergency treatment of any injury or illness my child may experience if qualified medical personnel consider treatment necessary and perform the treatment. This authorization is granted only if I cannot be reached and a reasonable effort has been made to do so.

Dated this the _____ day of _____, 20___. _____
Parent/Guardian

Please email completed form to uhslacrosse@comcast.net.
Or mail form with payment of $20/entrant to (checks made out to UHS Boys Lacrosse Boosters):
Boys Lacrosse Clinic c/o Kim Di Biaggio
1006 General Stevens Drive
West Chester, PA 19382