2013 Worthington Field Hockey Clinics

DATES: March 16 and/or April 6
TIMES: 2:00-4:00 P.M. on 3/16 and 9:00-11:00 on 4/6
WHO: Open to ALL 1st – 7th Graders!
(Base age on the 2012-2013 School Year)
WHERE: TWHS Auxiliary Gym
COACH: Terri Simonetti and TWFH Players
FEE: March 16 = $25 April 6 = $25
OR BOTH DATES = $40 (CIRCLE ONE OPTION)

PLEASE PRINT ALL INFORMATION NEATLY (FILL OUT THE BACK TOO)

Player's Full Name: ______________________________
Parent(s) Name(s): ______________________________

Home Phone: ______________________________
Emergency Contact Phone #: ______________________________

Address: ______________________________
City, State, Zip ______________________________

E-Mail Address: ______________________________

School Attending 2012/13: ______________________________
Grade 2012/13: ______________________________

Which High School will you attend? ______________________________
Have you ever played Field Hockey? ______________________________
No. Years played: ______________________________

Please complete this form and return it with a check or money order in the amount of $25.00 *OR* $40.00 made payable to: *TWFH Parent Group*.
Mail to: *Central Ohio FH Coaches Assoc. c/o Terri Simonetti P.O. Box 4011 Dublin, Ohio 43016*
Each camper will need: shinguards, mouthguard, goggles, stick, sneakers, and a water bottle. If you have any questions, please email me at:
Terri_Simonetti@hboe.org

EMERGENCY MEDICAL AUTHORIZATION PART 1 OR 2 MUST BE COMPLETED

Please PRINT

Student'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 or Legal Guardian Date ______________________________