



## **2009/2010 GIRLS LACROSSE CLINICS**

**For Girls in 5<sup>th</sup> - 8<sup>th</sup> Grades**

**Off Season Clinic Dates**

- **Saturday, Oct. 3, 2009, 10am-12pm @ Founder's Field (drop-in fee \$10)**
- **Saturday, Oct. 31, 2009, 10am-12pm @ Founder's Field (drop-in fee \$10)**
- **Sunday, Dec 6, 2009, 11am -1pm @ Pinnacle Sports (drop-in fee \$15)**
- **Sunday, Jan. 10, 2010, 11am-1pm @ Pinnacle Sports (drop-in fee \$15)**
- **Sunday, Feb. 7, 2009, 11am-1pm @ Pinnacle Sports (drop-in fee \$15)**

*5<sup>th</sup> & 6<sup>th</sup> graders are encouraged to attend all 5 clinics and new players must register on-line at [www.uslacrosse.org](http://www.uslacrosse.org) before attending any clinics.*

*Returning (7 & 8th grade) players should plan to attend at least 2 clinics and need to renew their US Lacrosse Registration if expired. Pinnacle Sports is the former Edge Facility in Twinsburg.*

***\*\*\*Single Price for all 5 clinics is \$50.00. Please Make Checks Payable to CAA \*\*\****

*Mail checks, registration and medical waiver to Ruth Clemens @ 102 Spring Drive, 44022. Please call, 338-4470 or email: [ruthclemens@juno.com](mailto:ruthclemens@juno.com) if you have any questions. Mouth guard and goggles are mandatory. We have a few goggles and sticks available to borrow, please indicate if equipment is needed.*

**Parent Lacrosse Meeting: February 2010 (TBD)**

**Team Tryouts: March, 2010**



**Registration**

**Player's Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Parents Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Cell** \_\_\_\_\_ **Email:** \_\_\_\_\_

**US Lacrosse #:** \_\_\_\_\_ **Clinic Dates Attending:** \_\_\_\_\_

**Goggles or Stick Needed ? Please Circle.**

**2009/2010 EMERGENCY MEDICAL AUTHORIZATION FORM**

The purpose of this document is to enable parents or guardians to authorize the provision of emergency treatment for children who become ill or injured at the Girls Lacrosse Clinics when parents cannot be reached.

**MEDICAL INSURANCE INFORMATION**

Insurance Provider: \_\_\_\_\_ ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

**GRANT OF CONSENT**

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

In the event of reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above mentioned medical providers, or in the event the preferred practitioners are not available, by another licensed physician or dentist; and the transfer of the child to any hospital reasonably available.

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.

Printed Name: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

Date Signed: \_\_\_\_\_

