

HEIGHTS HOLIDAY LACROSSE CLINIC

For Girls in Youth & Middle School (Grades 4-8)

Wednesday, January 3-Friday January 5, 2018

9:00 am-12:00 pm

Heights High School - Auxiliary Gym



Looking for something fun to do after the holidays? Join us for the Heights Holiday Lacrosse Clinic - new and experienced players welcome!

The Heights High Girls Lacrosse team will lead a pre-season lacrosse clinic for girls in grades 4-8. The program will be supervised by the Heights High School Girls Lacrosse team and assisted by the coaching staff. Players will work on basic skills and techniques of the game in a fun environment. Players will learn to pass, catch, cradle, scoop and shoot as well as individual defense and offense. Experienced players will receive individualized coaching designed to sharpen these skills while learning team offense and defensive play. Players will participate in 4v4 team scrimmages.

COST IS \$50 per student player, and all players need a lacrosse stick and mouth guard. To enroll please complete the form below including medical information on the second page and return with your **check to Heights Lacrosse, c/o Carol Iott, 2711 Colchester Road, Cleveland Hts, OH 44106.** For additional information contact Carol Iott at 708-606-0863 or j.iott@sbcglobal.net

Player's Name: _____ Phone: _____

Address: _____

City: _____ Zip Code: _____ Email: _____

Birthdate: _____ Lacrosse experience? Yes No

School: _____ Grade _____

In consideration of Heights Lacrosse accepting the above-named player in the Holiday Lacrosse Clinic, I as the parent/guardian of the above entrant, do hereby release, indemnify, and save harmless Heights Lacrosse and its coaches and staff from any and all claims for injuries to person or property sustained or caused by said entrant while participating in said lacrosse program. I also accept financial responsibility for any damages inflicted by said entrant on the property or properties of the City of Cleveland Heights or the Cleveland Heights-University Heights School District.

Signed this _____ day of _____ 2017

Signature of Parent/Guardian: _____

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MEDICAL AUTHORIZATION

Name of Player: _____ Birth Date: _____

CIRCLE ONE IN EACH PARAGRAPH:

1. I hereby **(GRANT PERMISSION TO) (WITHHOLD PERMISSION FROM)** the staff physician of any state or provincially approved hospital to give any treatment or perform any test that they deem necessary on the above named player.

2. I hereby **(AUTHORIZE) (DO NOT AUTHORIZE)** any physician, licensed by the state or province in which he practices, or a member of any state or provincially approved hospital to administer any anesthetic or perform any surgical procedure they deem necessary on the above named player.

CHECK ONE OF THE FOLLOWING:

_____ The above-named player has no unusual medical problems.

_____ The above-named player has the following allergies, sensitivities to drugs or other special medical problems or conditions:

Signed this _____ day of _____ 2017.

Signature of Parent/Guardian: _____

Print Name: _____

Relationship: _____ Phone: _____

Address: _____

Secondary Contact: _____ Phone: _____

Address: _____ Relationship: _____

Preferred Hospital: _____

Preferred Physician: _____ Phone: _____

The above consent form is provided for the protection of your child should he/she become ill or be injured as a result of participation in the Heights Lacrosse Program. NO TREATMENT OTHER THAN FIRST AID, WILL BE INITIATED WITHOUT FIRST ATTEMPTING TO CONTACT YOU, HIS/HER PARENTS. These forms will be invoked to authorize emergency medical treatment only if you are not immediately available to grant the appropriate permission.

Please note that if authority is withheld, medical personnel may decline to begin treatment of any non-life threatening condition until permission is obtained from a responsible adult, even if this means several hours of discomfort for your child.