STICK TO STICK FIELD HOCKEY CAMP

Extended Day at Denison University

June 16-18, 2023

PLEASE PRINT INFORMATION BELOW OR ENROLL ONLINE AT WWW.STICKTOSTICKFIELDHCOKEY.COM

Name

Camper E-Mail *Cell Phone*

Address

City *State* *Zip*

Parent or Guardian

Cell Phone

E-Mail (will be used to send confirmation and additional details)

School *Date of Birth*

Grade in Sept *Position*

Years of FH Experience *Level(*Beginner/MS/JV/Varsity)

T-Shirt Size (circle) *Small* *Medium* *Large* *XL*

Session Information

June 16 *2:00-4:30 p.m. & 6:30-8:30 p.m.*
June 17 *9:00 a.m.-12:00, 2:00-4:30 p.m. & 6:30-8:30 p.m.*
June 18 *9:00 a.m.- 12:00 p.m.*

COST $425 **Pro-Rated $150/Day x _____ days**

June 16-18 I will attend the following dates_____

***Dinner will be the first meal at camp. Lunch and dinner will be provided on the second day. Please be sure to indicate any food allergies/dietary restrictions/preferences**

Make checks payable and mail to
STICK TO STICK FIELD HOCKEY
1842 Elmwood Ave.
Columbus, OH 43212

HEALTH INFORMATION

Insurance Information

Name of Medical Insurance Company *Policy Number*

Insurance Policy Holder *Group Number*

In case of emergency please contact

Emergency Contact

Emergency Cell Phone

Medical Information

List any Allergies (including bees)

List any Medications

List any Dietary Restrictions

Any Medical Conditions that camp personnel should be aware of

Do you have Asthma that requires the use of an inhaler? Y N

Have you had any of the following illness (please circle):

Covid-19	Measles	Mumps	Rubella
Chickenpox	Rheumatic	Fever	Polio

Immunization Dates

Covid 19_____**Covid 19**_____**Covid Booster**_____

Tetanus_____**Influenza**_____**Pneumonia**_____

Hepatitis_____**Chickenpox**_____**MMR**_____

As a parent or legal guardian of the participant named above, authorizes Stick to Stick to seek medical care and/or surgical treatment which is reasonable necessary to care for the patient. I further authorize the medical facility that treats the participant to release all information needed to complete insurance claims. I acknowledge my responsibility to pay all cost associated with the participant's medical care and authorize all insurance payments, if any to be made directly to the medical staff.

Signature (Parent or Guardian) Date