

STICK TO STICK FIELD HOCKEY
Extended Day Camp
DENISON UNIVERSITY
June 7-9 2024

*PLEASE PRINT INFORMATION BELOW OR ENROLL ONLINE AT
WWW.STICKTOSTICKFIELDHOCKEY.COM*

Name _____

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 7 2:00-4:30 p.m. & 6:30-8:30 p.m.
June 8 9:00 a.m.-12:00, 2:00-4:30 p.m. & 6:30-8:30 p.m.
June 9 9:00 a.m.- 12:00 p.m.

COST \$425

Pro-Rated Option

(for those who are not able to attend all three days)

\$150/Day x _____ days 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 to
STICK TO STICK FIELD HOCKEY
1842 Elmwood Ave.
Columbus, OH 43212

a \$100 Non-Refundable deposit is required

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

| | | |
|-----------------|------------------|-----------------|
| 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 _____

