



# SAINT MICHAEL'S COLLEGE GIRLS FIELD HOCKEY CAMP APPLICATION



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Position: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ T-Shirt Size (*circle one*): Child: L Adult: S M L

Grade entering in fall: \_\_\_\_\_ School: \_\_\_\_\_ Age (*at time of camp*): \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ Parent's Day/Work Phone: \_\_\_\_\_

E-mail for confirmation: \_\_\_\_\_ Years of playing experience: \_\_\_\_\_

**A deposit of \$100 is required for EACH WEEK OF CAMP your child will be attending. The balance of camp fees is paid upon registration. Please complete statement of health form below. (\$25/camp is non-refundable.) Any incomplete application will be returned and will delay your registration for camp.**

### Please indicate session desired for Camp that your child will be attending:

All camps have age restrictions: please refer to individual camp brochures. Applications not meeting age criteria will be returned.

CAMP/PRICE	DATES	APPLICATION DEADLINE
_____ Girls Field Hockey Day Camp (\$205) (maximum 100)	August 3-7, 2009	July 20, 2009
_____ Girls Field Hockey Overnight Camp (\$350) (camper maximum 100)	July 26-30, 2009	July 6, 2009
_____ Commuter (\$275)	July 26-30, 2009	July 6, 2009

Roommate requested for Overnight Camp (*optional*): \_\_\_\_\_

*Office Only:* Date Rec'd: \_\_\_\_\_ Amount Pd: \_\_\_\_\_ Check #: \_\_\_\_\_ Amount Due: \_\_\_\_\_ Initials: \_\_\_\_\_

## SAINT MICHAEL'S COLLEGE GIRLS FIELD HOCKEY CAMP HEALTH FORM

In case of emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

I understand our family will provide insurance coverage if our daughter is injured while participating in one or more of the Saint Michael's College Girls Field Hockey Camps:

**Health Insurance:**

**Family Doctor:** \_\_\_\_\_

Co. \_\_\_\_\_

Policy #: \_\_\_\_\_

I hereby state that my daughter is in good health and may participate in one or more of the Saint Michael's College Girls Field Hockey Camps. I also give permission to the attending health professional, in case of emergency, to allow my daughter to be treated in the hospital emergency room, if necessary.

Printed name of Parent/Guardian \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

Please list any special health problems or special circumstances: \_\_\_\_\_

Please make checks payable to *Saint Michael's College*.

**Return to:** Saint Michael's College Summer Athletic Camps, Athletic Department, One Winooski Park, Box 258, Colchester, Vermont 05439