

SAINT MICHAEL'S COLLEGE BOYS LACROSSE 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
_____ Boys Lacrosse Day Camp (\$225)	June 21–25, 2010	June 5, 2010
_____ Boys Lacrosse Overnight Camp (\$375) (camper maximum 100)	June 27–30, 2010	June 14, 2010
_____ Commuter (\$295)	June 27–30, 2010	June 14, 2010
<div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> Roommate request for overnight camp (optional) _____ </div>		

Office Only: Date Rec'd: _____ Amount Pd: _____ Check #: _____ Amount Due: _____ Initials: _____

SAINT MICHAEL'S COLLEGE BOYS LACROSSE CAMP HEALTH FORM

In case of emergency contact: _____ Phone: _____

I understand our family will provide insurance coverage if our son is injured while participating in one or more of the Saint Michael's College Boys Lacrosse Camps:

Health Insurance: _____ **Family Doctor:** _____
 Co. _____
 Policy #: _____

I hereby state that my son is in good health and may participate in one or more of the Saint Michael's College Boys Lacrosse Camps. I also give permission to the attending health professional, in case of emergency, to allow my son 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