

Sponsored by Wickliffe Recreation Department

LIGHTNING YOUTH SOCCER CAMP

For Boys and Girls currently in K – 8



WHEN: August 2 – August 6
TIME: 9:00 am - 11:30
COST: Residents, \$50 includes instruction, shirt and ball, \$40 for each additional child in family
Non-resident, \$70 includes instruction, shirt and ball, \$55 for each additional child in family
WHERE: Orlando Park
COACH: John Scramling, Brush High School Boy's Varsity Coach. 440-943-3466
or e-mail jbscram@aol.com

PLAYER CONTRACT, PLEASE FILL OUT IN CHILD'S NAME.

NAME BIRTHDATE GRADE ENTERING 09-10
ADDRESS CITY/STATE/ZIP AGE
HPHONE CPHONE E-MAIL

CIRCLE SHIRT SIZE SM.YOUTH M.YOUTH L. YOUTH SM. ADULT M. A L.A XLA

My child agrees to participate in the Lightning Youth Soccer Camp. In case of injury, while participating , we the parents of the above name child, will not hold the coaches, instructors, or the City of Wickliffe responsible for any injury incurred at the above function.

SIGNED BY: (Parent or Legal Guardian Signature)

PLEASE PRINT PARENT'S NAMES:

MOTHER: FATHER:

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while at the Lightning Soccer Club Summer Camp, when parents or guardians cannot be reached.

TO GRANT CONSENT:

In the event reasonable attempts to contact me or my spouse have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by:

Physician Dr. Phone
Dentist Dr. Phone

or if neither is available, by another licensed physician or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity of such surgery are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken and physical impairments to which a physician should be alerted:

Signature of parent Date

REFUSAL TO CONSENT: (DO NOT COMPLETE IF TO GRANT CONSENT ABOVE IS COMPLETED)

I do not give my consent for emergency medical treatment for my child. In the event of illness or injury requiring emergency treatment, I wish the Camp authorities to take no action.

Signature of parent Date

Mail to: Wickliffe Recreation
28730 Ridge Rd.
Wickliffe, Ohio 44092

Circle Fee Enclosed: \$50.00 Resident \$70.00 Non-Resident
Additional child(children) in the family \$ Make checks payable to City of Wickliffe.