2016
University of Rochester
Girl’s Lacrosse Clinic

University of ROCHESTER welcomes you…

Date: Monday January 18, 2016

Time: 1:00 pm – 3:00 pm

Grades: 9th - 12th

Location: University of Rochester Goergen Athletic Center Field House
*Field house is turf surface.
*If weather permits, we may use Fauver Stadium outdoor turf field.

Cost: $40.00

*Once we receive your registration we will email you clinic check in details, etc.

*Clinic flyer, registration form, and all additional required paperwork is also located at www.uofrathletics.com on women’s lacrosse page under additional links.
2016
University of Rochester
Girl’s Lacrosse Clinic
Registration Form

Player’s Name: ______________________________________________
Address: ____________________________________________________
City: ________________________ State: ________ Zip: _______________
Phone: ______________________________________________________
Parent / Legal Guardian Name: _________________________________
Parent / Legal Guardian Address & Phone: _________________________
Emergency Name & Phone: _____________________________________
Parent’s Email (PLEASE print clearly): ____________________________
________________________________________________________________
Participant grade: ___________________
Age during clinic: __________
Position: Field Player _______________ Goal Keeper _____ (please check if applicable)

*PLEASE RETURN ALL REQUIRED INFORMATION VIA MAIL TO COACH SUE BEHME (ADDRESS BELOW):
1. REGISTRATION FORM
2. GIRL’S LACROSSE WAVIER FORM FOR MINORS
3. MEDICAL FORM
4. FULL PAYMENT
   Check Accepted Only / Payable to University of Rochester
   $40.00

*GIRL’S LACROSSE WAVIER FOR MINORS & MEDICAL FORMS ARE BELOW.

*REGISTRATION CONFIRMATION & DETAILS WILL BE SENT VIA EMAIL.
PART I
Acknowledgement and Release Agreement

I, _____________________________, am the parent or legal guardian of ___________________, whom I wish to participate in the GIRLS LACROSSE CLINIC 9TH, 12TH GRADE (the Activity) offered by University of Rochester. As a precondition to Participant participating in the Activity, I have read the following Release Agreement and agree to its terms.

1. Assumption of Risk. I understand that participating in the Activity entails inherent risks including, but not limited to, the risks described in this Activity Detail Form on the reverse side of this Release Agreement. I have read and understood the Activity Detail Form. I have been given the chance to ask questions about the Activity Detail Form and all such questions have been answered to my satisfaction.

2. Liability Release. In consideration for U of R allowing me to participate in the Activity, I agree I will not sue the Releasees and I hereby release and indemnify the Releasees from any and all liabilities, claims, demands, actions, causes of actions, costs and expenses of any nature whatsoever arising out of any loss, personal injury (including death) or property damage, that I may sustain as a result of participating in the Activity, unless caused by the gross negligence or willful misconduct of U of R, its officers, trustees, agents, employees or volunteers (the "Releasees"). I understand that I am not required to participate in the Activity and that I choose do to voluntarily and free of duress.

3. Statement of Physical Fitness. I state that I am physically fit and in a condition that will allow me to participate fully and safely in the Activity. I maintain medical insurance that covers me for accidents and illnesses while I am participating in this Activity. I understand the Releasees have not made, nor will make, any investigation into my physical fitness or ability to participate in the Activity and Releasees are relying on my statement of my physical condition. I assume full responsibility for payment of medical expenses not covered by my insurance incurred as a result of my participation in the Activity.

4. Emergency Medical Treatment. I grant the Releasees permission to authorize emergency medical treatment as they deem appropriate, and agree that such action by the Releasees shall be subject to the terms of this Agreement. I understand and agree that the Releasees assume no responsibility for any injury or damage that might result from such emergency medical treatment.

5. Governing Law. I agree that this Agreement and any claim arising from my participation in the Activity shall be construed in accordance with the laws of the State of New York, without regard to its conflict of laws principles. The courts in Monroe County shall be the forum for any lawsuits arising from the Activity or relating to this Agreement. The terms of this Agreement shall be severable, such that if a court of competent jurisdiction holds any term to be illegal or unenforceable, the validity of the remaining portions shall not be affected thereby.

In the event of an emergency, the emergency contact that is listed on my registration form will be contacted via phone by a staff member as soon as possible.

ACTIVITY DETAIL FORM
Name of Activity: 2016 GIRL’S LACROSSE CLINIC
Date(s) of Activity: MONDAY JANUARY 18, 2016 1:00 – 3:00 PM
Location of Activity: GOERGEN ATHLETIC CENTER FIELD HOUSE & FAUVER STADIUM
Description of Activity: Participation in GIRL’S LACROSSE CLINIC, which may include training, practices, drills and competitions, some of which may involve bodily contact with others and with equipment.

By participating in these activities you may be exposed to several inherent risks, including but not limited to those listed below:
Physical injury, including but not limited to broken bones, concussions or other head injuries, organ damage, torn ligaments and tendons, cardiac injury, and even death. These may be accompanied by psychic injury or mental anguish. These risks may result from participation in practices, training drills and competitions, and during travel to and from practices and competitions.

In signing this Agreement, I acknowledge that I have read both sides of this Release Agreement form, understand it, and agree to be bound by its terms. I further acknowledge that I sign this Release Agreement voluntarily and I am at least eighteen years of age (or that I am the Parent/Guardian of the Participant if he or she is under 18).

Name of Parent or Legal Guardian (printed) ____________________________ Signature ____________________________

Name of Participant (printed) ____________________________ Phone number where parent/legal guardian can be reached in case of emergency ____________________________ Date ____________________________

THIS IS A RELEASE OF LEGAL RIGHTS. READ AND UNDERSTAND BEFORE SIGNING. (Rev. 4/98)
PART II

2016 GIRL’S LACROSSE CLINIC
9th – 12th GRADE

Rules and Regulations

1) The possession or use of alcohol and other drugs, fireworks, guns and other weapons is prohibited.

2) Participants may not leave University property or the program without permission of the Program Sponsor.

3) No violence by anyone involved with the, including sexual abuse or harassment, will be tolerated. Hazing is prohibited. Bullying, including verbal, physical, and cyber bullying, are prohibited.

4) No use of tobacco products.

5) Misuse, damage or theft of property is prohibited. Charges will be assessed against those participants who are responsible for damage, theft or misuse of University property.

6) Participants must follow all safety rules in accordance with University standards and/or as defined by the program administrator.

7) Use of cameras, imaging, and digital devices is prohibited where privacy is expected, such as showers, locker rooms and restrooms.

8) As the parent or legal guardian, I declare that I have read, understand, and approve the rules, and give permission for my child to participate in ELITE GIRLS LACROSSE CAMP.

Any participant who is found behaving in direct violation of these rules will be removed from the GIRLS LACROSSE CLINIC immediately.

In signing this Agreement, I acknowledge that I have read Part II of this Release Agreement form, understand it, and agree to be bound by its terms. I further acknowledge that I sign this Release Agreement voluntarily and I am at least eighteen years of age.

____________________________________  ______________________________________
Name of Parent or Legal Guardian (printed)  Signature

____________________________________
Name of Participant (printed)

____________________________________
Date
PART III

Emergency Contact Information
(Parent/Guardian to keep this page)

In the event of an emergency during the activity that requires immediate contact of the coaching staff, a participant, or UR security, please use the contact information listed below to reach the staff members.

(List coaches who will be at event):
Name Sue Behme Office: 585-275-1030 Cell: 585-789-8170

UR Security – (585) 275-3333

In the event of an emergency (medical, behavioral, disaster, or significant program disruption) during the activity that requires immediate contact of the participant’s parent/guardian, the staff will use the emergency the contact name and phone number which were provided by the participant. This information is recorded and filed by the staff as a part of the registration process.
2016 UNIVERSITY OF ROCHESTER LACROSSE CLINIC
MEDICAL HISTORY FORM

Please return this form by mail with all registration requirements.

To Whom It May Concern:

I, __________________________, give permission for first aid or medical treatment to be given to my daughter, __________________________ if deemed necessary by the Certified Athletic Trainer or qualified physician. The following health history is correct as far as I know, and the permission to engage in all prescribed camp activities, excepted as noted by our family doctor or me is given.

__________________________  __________________________
(Date)  (Signature of Parent/Guardian)

Camper’s Full Name: ____________________________________________________________

Address: ____________________________________________ City/State/Zip: ________________

Phone Number: ( ) ____________________________ Parent/Guardian Name: _______________

Emergency Contact: ____________________________ Emergency Number: ( ) ______________

Family Doctor’s Name: __________________________________________________________________

Family Doctor’s Address: __________________________________________________________________

City/State/Zip: ____________________________ Doctor’s Phone: ( ) ______________

Does the camper have medical insurance?  Yes or No (please circle)

Insurance Carrier Name: __________________________________________________________________

Insurance Policy Number/Group: __________________________________________________________________

Insurance Carrier Phone Number: ( ) ______________

Last Tetanus and Immunizations against diphtheria, measles, mumps, poliomyelitis and rubella:
(Please include dates) ____________________________________________

____________________________________________________________________________________

Has the camper had a physical examination performed within the last year?  Yes or No

Does the camper have any allergies? If yes, please list. _______________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Does the camper currently take any medication (s) or does she have any reactions to penicillin or any other prescriptions? If yes, please list. _______________________________________

____________________________________________________________________________________

____________________________________________________________________________________