



**WESTERVILLE CENTRAL SOFTBALL
DEFENSIVE SKILLS CAMP
July 17th and 18th 2018**



July 17th and 18th, 2018 (Tuesday & Wednesday)

12:00 pm - 5:00 p.m.

(Hosted by Local Coaches and Central players (past and present) for ages 9-14

Westerville Central High School

7118 Mount Royal Ave.

JV and Varsity Field

Registration Cost:

\$65.00 (pre-register by 7/11)

No day of or walk-up registration available

Space is Limited. Register early to guarantee a spot!

Players should bring: All softball related equipment, softball pants (no shorts please), cleats, water and healthy snack.

Camp T-shirt

Mail with registration form to:

WCHS Athletic Office Attn: Softball Defensive Skills Camp

7118 Mount Royal Avenue Westerville, Ohio 43082

Phone: (614) 774-6401 (Jay) E-mail: jmcomp25@gmail.com for questions or concerns

Make your checks payable to WCABC.

Westerville Central Softball Defensive Skills Camp 2018

PLEASE PRINT CLEARLY

Last Name: _____	First Name: _____
Age: _____	Grade Entering Fall 2019: _____
T-Shirt Size (please circle): YM YL AS AM AL AXL	
**Medical Conditions/Allergies: _____	

Injury and Insurance Release Statement: I give my permission for my child to participate in the Westerville Central Softball Camp. In addition, I agree to accept any and all liability in case of accident or injury.

*****Parent/Guardian Signature for Insurance Release: _____ Date: _____**

Emergency Medical Authorization (Section 3313.312 Ohio Revised Code)

Parent/Guardian Name(s): _____	Phone: (____) _____ - _____	Cell: (____) _____ - _____
Street Address: _____	City: _____	Zip Code: _____
Parent E-mail (PLEASE USE ALL CAPS) _____		

Purpose: To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

PART I or PART II must be complete.

PART I CONSENT – In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the admission of any treatment deemed necessary by (preferred physician) _____ @ phone _____ or (preferred dentist) _____ @ phone _____, or in the event that the preferred practitioner is not available, by any other licensed physician or dentist, and transfer of the child to (preferred hospital) _____ or any other hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is performed. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted to _____. Date: _____ Signature: _____

PART II – REFUSAL TO CONSENT – I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish school authorities to take no action or to _____.

Date: _____ Signature: _____