SJCC Girls Basketball Camp

Please fill out application completely and return by June 6, 2025
Camp Fee: $50.00
Camp Dates: June 16-20
Make Checks Payable To: SJCC

FOR CAMP USE ONLY

Amount Paid:_____

Amount Due:_____

Each Camper will receive a T-Shirt.

Mail To: Girls Basketball Camp
St. Joseph Central Catholic
702 Croghan Street
Fremont, Ohio 43420-2417

Name: _____
(Last) *(First)*

Address:_____ ***T-Shirt Size*** **YLg S M Lg XLg**
(Number) *(Street)*

_____
(City) *(Zip)*

Grade in September: _____
Height: ____'____"
School you played for last year:_____
School you will be playing for next year:_____

Have you attended this camp before
Yes **No**

Waiver of Liability
I as the parent/legal guardian of the below named student in consideration of my son/daughter's application being accepted, intending to be legally bound, do hereby waive, release, and forever discharge Bishop Hoffman Catholic School, the Diocese or Toledo, it's employees, coaches, or volunteers from all rights and claims for damages, injury, loss to person or property which may be sustained or occur during participation in Camp activities. I further attest the below named applicant is physically capable to participate in all events. Further, I attest the below named applicant's health insurance will cover any medical and hospital expense that he or she incurs; and that he or she has passed a sports participation medical exam within the past year. BHCS reserve the right to refuse admission to any students at any time it is in the best interest of the Camp or the participants.

Student's Name (Please print)_____ Birth Date: _____

Medical Consent

In the case of a medical emergency and reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) administration of any treatment deemed necessary by a licensed medical professional, and (2) the transfer of my child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians, concurring in the necessity for each surgery, are obtained prior to the performance of such surgery.

Facts concerning the above named student's medical history, including allergies, medications being taken, and any physical impairment(s) to which a licensed medical professional, should be alerted:

_____
_____
_____
_____

Parent/Legal Guardian Signature_____Date_____

Parent Cell Phone # _____