

SJCC Boys Basketball Camp

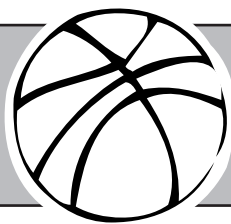
Three Days
of Basketball
Skills and Drills



*Crimson
Streaks*

Only
\$30.00

June 24 - 26, 2024
Incoming 4th - 8th graders
Fundamental Camp 10:00 - 12:00



B A S K E T B A L L

SJCC Boys Basketball Camp

Please fill out application completely

Camp Fee: \$30.00

Camp Dates: June 24-26

Make Checks Payable To: SJCC

Can be turned in at SJCC office
or first day of camp.

FOR CAMP USE ONLY

Amount Paid: _____

Amount Due: _____

Each Camper will receive a T-Shirt.

Mail To: Boys Basketball Camp
St. Joseph Central Catholic
702 Croghan Street

Name: _____
(Last) (First)

Address: _____
(Number) (Street)

T-Shirt Size

YLg S M Lg XLg

(City) (Zip)

Grade in September: _____

Have you attended this camp before

Height: ____' ____"

Yes

No

School you played for last year: _____

School you will be playing for next year: _____

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 of Toledo, its 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 # _____