

DEADLINE TO REGISTER FOR THIS CAMP IS SATURDAY, JUNE 3RD



CHICAGO CELTIC YOUTH GAELIC FOOTBALL CLUB
2006 SUMMER CAMP REGISTRATION FORM AND INFORMATION SHEET
CAMP DATES: JUNE 19 - 23 TIME: 12:00PM - 4:00PM
LOCATION: PRAIRIE VIEW PARK, 6834 DEMPSTER ST., MORTON GROVE
FEE: \$50 PER PLAYER LIMIT: \$100 PER FAMILY

Player's First Name: _____ Last Name: _____ Birthdate: _____
Player's First Name: _____ Last Name: _____ Birthdate: _____
Player's First Name: _____ Last Name: _____ Birthdate: _____
Player's First Name: _____ Last Name: _____ Birthdate: _____

Family Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Email Address: _____

Allergies, diseases, disorders, or disabilities: _____

Special circumstances the Club should be aware of: _____

Indicate mode of transportation leaving camp: _____ By Parent _____ Car Pool _____ Riding Bike/Walk/Rollerblade

EMERGENCY CONTACTS: Include authorized individuals to contact if unable to reach parents.

1. Name: _____ Phone: _____

2. Name: _____ Phone: _____

WE ARE IN NEED OF PARENT VOLUNTEERS TO RUN A SUCCESSFUL CAMP. PLEASE CIRCLE ANY AND ALL DAYS THAT YOU MIGHT BE AVAILABLE TO HELP DURING THE HOURS OF 12PM-4PM:
VOLUNTEER'S NAME: _____

MONDAY, JUNE 19 TUESDAY, JUNE 20 WEDNESDAY, JUNE 21 THURSDAY, JUNE 22 FRIDAY, JUNE 23

IMPORTANT I, the parent/guardian of the registrant, a minor, agree that I and the registrant will abide by the rules of the GAA, its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with Gaelic Football and in consideration for the GAA accepting the registrant for its Gaelic Football programs and activities (the "Programs", I hereby release, discharge, and/or otherwise indemnify the GAA, its affiliated organizations and sponsors, their employees and associated personnel, including the owners of fields and facilities utilized for the Programs, against any claims by or on behalf of the registrant as a result of the registrant's participation in the Programs, and/or being transported to or from the same, which transportation I hereby authorize.

Name of Parent/Legal Guardian (Please Print) _____

Signature _____ Date _____

CONSENT FOR MEDICAL TREATMENT (MINOR) - As the parent or legal guardian of the above-named registrant, I hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of my dependent.

Signature of Parent or Guardian _____ Date _____

Address: _____ City: _____ State: _____ Zip: _____

FOR REGISTRAR'S USE ONLY

Method of Payment Enclosed: Check _____ Cash _____ TOTAL: _____