



# St. Charles Floor Hockey Camp



Teams will be chosen from sign-ups on Monday, June 19th at 8:30AM. Regular season games will be held Monday – Wednesday starting at 9:00AM. Playoffs will be held on Thursday beginning at 9:00AM. Individual trophies will be awarded to our LaFontaine Cup Playoff Champions and Regular Season Champions Thursday after the final game. If you have any questions, please contact Mark Kenney at 612-787-1118 or mkenney@stchbs.org. Thank you and have a great summer!

**When:** Monday, June 19 – Thursday, June 22, 2017

**Who:** Boys and Girls entering 5<sup>th</sup> – 9<sup>th</sup> Grades in the fall

**Time:** 9:00AM – 12:30PM

**Where:** St. Charles Gymnasium --2727 Stinson Blvd. N.E. St. Anthony, MN

**What to bring:** Athletic shoes, shorts, t-shirt.

**Cost:** \$40.00 per participant (Please make checks payable to St. Charles Athletic Dept.)

**Please fill out the application below and return it to St. Charles by Friday, June 9<sup>th</sup>.**

**Please keep the top portion for your records. Thank you.)**

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**FAMILY INFORMATION**

Student/Participant \_\_\_\_\_ Grade (fall 2017) \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Best Phone #s to Reach You During This Camp: \_\_\_\_\_ , \_\_\_\_\_

I, \_\_\_\_\_, grant permission for my child, \_\_\_\_\_,  
Parent or Guardian's Name Student/Participant's Name

to participate in the above named activity and I warrant that my child is in good health. In consideration of my child's participation, I agree to indemnify the parish/school and the Archdiocese of St. Paul/Minneapolis from any claims or law suits brought against the parish/school/Archdiocese of St. Paul/Minneapolis by myself, my child or others, that arises out of any behavior by my child at the event/activity described above. I also agree to pay reasonable attorney's fees or expenses incurred by the parish/school and Archdiocese in defense of such a claim/law suit.

**EMERGENCY MEDICAL TREATMENT**

In the event of an emergency, I give permission to transport my child to a hospital for emergency medical treatment. I wish to be advised prior to any further treatment by a doctor or hospital. In the event of an emergency, if you are unable to reach me at the above numbers,

Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**As Parent or Guardian, I agree to all of the above stated considerations and conditions.**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

I understand the conditions for art camp and am willing to abide by these conditions.

**Signature of Student** \_\_\_\_\_



**Please return this form and the \$40.00 fee to the school office before June 9**

**Thank You.**