



**Irish 5 v 5 Lacrosse Clinic**

University of Notre Dame  
 Women's Lacrosse  
 Joyce Center  
 Notre Dame, IN 46556  
 (574) 631-8753  
[wlacrosse.1@nd.edu](mailto:wlacrosse.1@nd.edu)

**IRISH 5 v 5 LACROSSE CLINIC hosted by the University of Notre Dame**  
**Join us at Notre Dame October 18, 2008 from 9:00 am - 1:00 pm EST**

Program Join the Notre Dame Women's Lacrosse Team for a 1-hour training session lead by the Irish coaching staff and players. Learn the latest stick skills and tactical strategies from some of our favorite drills and then compete in a round robin 5 v 5 tournament with your team.

Eligibility This clinic is recommended for high school players in grades 9-12.

Application Procedures All prospective campers must submit the completed application, consent and health forms. To register as a team, you must have at least 5 players and 1 goalie. Teams are limited to 8 players, including 1 goalie. Individuals can register and will be assigned to a house team. All participants, even if they are registering as a team, must submit their own individual application form. Applications will be processed on a first-come, first-served basis until the 5 v 5 clinic is filled.

Camper's must bring their own stick and mouthguard. Goalies must bring full gear.

**Team Registration \$320.00**

**Individual Registration \$45.00**

Please make checks payable to the University of Notre Dame.  
 Please send check and application to the address above.

Team Name: \_\_\_\_\_

Teammates: (1) \_\_\_\_\_ (2) \_\_\_\_\_  
 (3) \_\_\_\_\_ (4) \_\_\_\_\_  
 (5) \_\_\_\_\_ (6) \_\_\_\_\_  
 (7) \_\_\_\_\_ (8) \_\_\_\_\_

Individual Player Information:

\_\_\_\_\_  
 Last First MI

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 Street City (\_\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
 State Zip Telephone

\_\_\_\_\_  
 Grade in Fall Age Height Weight

\_\_\_\_\_  
 Name of High School

\_\_\_\_\_  
 Name of Club Team

CONSENT TO TREATMENT LIMITATION AND WAIVER OF LIABILITY

In partial consideration of our child's acceptance into the Irish 5 v 5 Clinic, I/we as parents and/or legal guardians of \_\_\_\_\_ do hereby agree to limit the liability of Notre Dame, its employees, agents, officers, staff and physicians, to the coverage of the medical insurance policy covering participants in the Irish 5 v 5 Clinic as explained in this registration pamphlet, which I/we have read and understand. I/we further agree to waive all liability of the University of Notre Dame, its employee, agents, officers, staff and physicians, for any accident, injury (including death), illness or other mishap which might befall the above-named camper while traveling to or from, or during her attendance at the Irish 5 v 5 Clinic, which is not covered by said medical insurance policy.

Further, I/we hereby grant permission to the staff and physicians of the University of Notre Dame, any medical or surgical consultant deemed advisable, and any hospital to render to the above-named camper any medical and surgical treatment that they deem necessary. I/we understand that all possible effort will be made to inform me/us in case of such treatment.

\_\_\_\_\_  
Parent or Legal Guardian's Name (printed)

\_\_\_\_\_  
Signature

(\_\_\_\_) \_\_\_\_\_  
Phone: Day

(\_\_\_\_) \_\_\_\_\_  
Phone: Emergency

Health Form

To be completed and signed by camper's parents or legal guardians.

- ASTHMA
- HEAD INJURY/CONCUSSIONS
- BLEEDING DISORDERS
- HEART DISEASE
- CONVULSIONS/SEIZURES
- RHEUMATIC FEVER
- DIABETES

ALLERGIES TO DRUGS: \_\_\_\_\_  
 ALLERGIES TO FOODS: \_\_\_\_\_  
 LAST TETANUS IMMUNIZATION (date): \_\_\_\_\_  
 CURRENT MEDICATIONS: \_\_\_\_\_  
 CHRONIC OR RECURRING ILLNESSES: \_\_\_\_\_  
 OPERATIONS/INJURIES (including dates): \_\_\_\_\_  
 PHYSICAL RESTRICTIONS \*: \_\_\_\_\_  
 PHYSICIAN TELEPHONE: \_\_\_\_\_  
 DENTIST TELEPHONE: \_\_\_\_\_  
 MEDICAL INSURANCE: \_\_\_\_\_  
 POLICY NUMBER: \_\_\_\_\_

PARENT AUTHORIZATION/RELEASE OF INFORMATION

This health history is correct to the best of my knowledge and my daughter has my permission to participate in camp activities with the exception of those noted above\*.

I authorize University of Notre Dame Health Services to release medical information regarding the above named participant to interested parties including parents and family physician.

\_\_\_\_\_  
PARENT OR LEAGAL GUARDIAN MUST SIGN