

STANFORD WINTER CLINICS

DATES

Sunday, January 8th 3:00 pm - 5:00 pm
Monday, January 16th 3:00 pm - 5:00 pm
-MLK Holiday
Sunday, January 22nd 3:00 pm - 5:00 pm

CLINIC FORMAT

Clinics are open to 8-18 year olds. Each clinic will begin with an hour of instruction from the Stanford Lacrosse staff. Topics covered will include but are not limited to: stickwork, individual and team defense, man up and man down situations, and both individual and team offense. Immediately following instruction, there will be an hour for scrimmaging with your registration teams. Games will at least be 7 v 7, or full field scrimmaging if there are enough players to do so.

LOCATION

All sessions will be played on Stanford's Lax/Soccer practice turf located south of Cagan stadium on El Camino Real. Parking is free in the Varsity Lot located outside the Sunken Diamond Baseball Stadium. You may also park on El Camino Real.

COST

The Winter Clinic series is \$200.00 per player for all three dates. Checks can be made payable to: Change Your Level Lacrosse. Please send to:

Brooke McKenzie
Stanford Lacrosse
Arrillaga Family Sports Center
Stanford University
Stanford, CA 94305

Online Registration:

http://www.active.com/event_detail.cfm?event_id=2002306

REGISTRATION

Players can register as individuals or as a team. If you are choosing to register as a team, you must have **at least** nine field players and one goalkeeper. Registration must be in by **WEDNESDAY, JANUARY 4TH !!!**

WHAT TO BRING

Players are expected to bring their own equipment including a stick, goggles, footwear for turf and grass fields, a mouthguard, and a water bottle.

If you have any questions or concerns please contact Brooke McKenzie 650-723-9903 bmckenze@stanford.edu

Medical Form

Please read, fill out emergency contact info, print and bring to registration.

I hereby state that the camper named below has been examined by a licensed physician within the last year and is physically fit to participate in the program. I understand and accept that the risk of injury is possible while playing or practicing the sport of lacrosse and authorize Change Your Level Lacrosse Camp staff members to act for me according to their best judgment in any emergency requiring medical attention. Change Your Level Lacrosse Camp will not assume responsibility for any camper's medical or dental expenses incurred as a result of participation in this program.

Camper Name: _____

Emergency Contact: _____

Emergency Contact Home #: _____

Emergency Contact Cell #: _____

Date

Parent/Guardian Signature

MEDICAL HISTORY SURVEY

Name of Insurance Provider: _____

Insurance Company Phone #: _____

Policy #: _____

1. Does the participant have any condition that would preclude or limit participation in our programs? YES NO

If so explain:

2. Has the participant been informed that they have asthma? YES NO

If so, is it controlled by medication? YES NO

3. Has participant ever been informed they might have epilepsy, or ever experienced a seizure? YES NO

4. Has participant ever been treated for infectious mononucleosis, viral pneumonia, or another infectious disease during the past twelve months? YES NO

5. Has participant ever been treated for or informed by a medical doctor that they have a heart problem, a heart murmur, or high blood pressure? YES NO

6. Has participant ever been told they have hemophilia or other bleeding disorders or currently have easy bleeding or bruising? YES NO

7. Has participant ever been told they have a hernia? If so, is it repaired? YES NO

8. Has participant had any operations in the past two years? If yes, indicate the anatomical site and date: YES NO

9. Is participant taking any prescribed medications? If so, please indicate name of drug and indicate why it is prescribed and dosage: YESNO

10. Has participant ever been treated for Osgood-Sclatter (knee) Disease? YES NO

11. Has participant had a fracture during the past two years? If yes, indicate the site of the fracture and the date: YES NO

12. Has participant had any joint dislocation during the past two years? If so, please indicate which joint: YES NO

13. Is participant allergic to penicillin or any other medications? YES NO If so, please list:

14. Is participant allergic to insect stings or any food? YES NO If yes, please list:

15. Have there been any disciplinary, emotional, learning disabilities or other concerns, which we should be aware of? YES NO If so, please explain:

COMMENTS:

PARENT/GUARDIAN: All of the above questions have been answered completely and truthfully to the best of my knowledge.

Date

Parent/Guardian Signature

Emergency Contacts:

1) Name/Relationship to Camper: _____ Phone #: _____

2) Name/Relationship to Camper: _____ Phone #: _____