HILLIARD
DARBY
PANTHERS

DarbyBall

Panther Pride

FOOTBALL CAMP

GRADES K-8 **JUNE 3-5**

9AM-11:30 AM • **AT DARBY STADIUM**

THREE DAYS OF AN INCREDIBLE FOOTBALL FUN EXPERIENCE FOR ALL YOUNG SKILL LEVELS!

INSTRUCTORS
DARBY PANTHER VARSITY STAFF

darby football
hdarbyfootball

$75 REGISTRATION FEE
PER PLAYER

BRAD_BURCHFIELD@HBOE.ORG

Camp Registration Form

CAMPER'S NAME_____

Address_____

City_____State_____Zip_____

Phone (_____) _____

Grade (entering) _____ Age_____

School_____

Height_____Weight_____

Contact Person_____ Daytime Phone (_____)_____

Address_____

The 3 day camp will run **Tues June 3 thru Thurs June 5 9 AM-11:30 AM**

Please make checks payable to: **Darby Football Camp**

Send Registration to: **Attn: Brad Burchfield Hilliard Darby High School**
4200 Leppert Road Hilliard, Ohio 43026

Adult T-Shirt Size (check One)

_____Y Medium _____Y Large _____ Small _____ Medium _____ Large _____ X-Large ____XXL

EMERGENCY MEDICAL FORM

The purpose of this form is to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under our authority, when parents or guardians cannot be reached.

RESIDENTIAL PARENT OR GUARDIAN_____

Mother's Name_____

Daytime Phone (_____) _____

Father's Name_____

Daytime Phone (_____) _____

Name of Relative or Childcare Provider_____

Relationship_____

Daytime Phone (_____) _____

Address_____

I hereby give consent for the following medical care providers and local hospital to be called:

DOCTOR_____ PHONE (_____) _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent of (1) the administration of any treatment deemed necessary by the above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted, I have listed below.

_____

_____

_____

SIGNATURE OF PARENT / GUARDIAN_____DATE_____