

# CENTRAL WASHINGTON UNIVERSITY

## Boys and Girls Basketball Camp

**CAMP DATES:**

June 27-30: (K-3)  
 June 27-30: (4-8)

TIME: 8:30-11:30 a.m.  
 TIME: 12:30-3:30 p.m.



*Central Washington University's Women's Basketball team and staff would like to welcome you to our boys and girls summer basketball camp! Our focus for four days is on in depth offensive and defensive skill development that will include drills, competitive games, and controlled scrimmages. Each camper will receive a T-shirt and camp basketball. Don't miss out on this great opportunity for four days of fun!*

**FOR MORE INFORMATION:**

You can contact CWU Women's Basketball

**Head Coach Jeff Whitney**

Office Phone: (509) 963-1934

Email: [whitneyj@cwu.edu](mailto:whitneyj@cwu.edu)

**Assistant Coach Rachael Ziemann**

Office Phone: (509) 963-1936

Email: [rziemann@cwu.edu](mailto:rziemann@cwu.edu)

**CAMP LOCATION:**

Central Washington University

**Nicholson Pavilion**

***REGISTRATION FORM: Checks payable to CWU Athletics***

Name of Camper \_\_\_\_\_ Age \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

(Please print)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ T-shirt Size \_\_\_\_\_

**Submission Options:**

**MAIL COMPLETED FORM TO** - CWU Women's Basketball 400 E UNIVERSITY WAY, ELLENSBURG, WA 98926

**FAX** - (509) 963-2390 with ATTN: Women's Basketball

**Email** -Coach Whitney or Coach Ziemann

June 27 - 30 (K-3)                      8:30-11:30 a.m.                      \$85.00                      Cost \_\_\_\_\_

June 27-30 (4-8)                      12:30-3:30 p.m.                      \$85.00                      \_\_\_\_\_

**\*\*ALL PLAYERS ARE REQUIRED TO WEAR BASKETBALL ATTIRE\*\*\***

**\*\*EACH CAMPER SHOULD BRING A WATER BOTTLE**

**TOTAL = \_\_\_\_\_**



# CWU CAMPER HEALTH/EMERGENCY INFORMATION FORM FOR CWU SPORT CAMPS

THIS FORM MUST BE PROPERLY SIGNED and RETURNED ON THE FIRST DAY OF CAMP.  
Campers will not be allowed to participate without properly completed and signed forms.

Camper's Name \_\_\_\_\_ Address \_\_\_\_\_

Birth Date \_\_\_\_\_ State/City Zip Code \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Sport Camp Attending \_\_\_\_\_

Does your child have:

Allergies  Yes  No If yes, list. \_\_\_\_\_

Chronic Illness, such as heart condition, asthma, epilepsy, diabetes, etc.  Yes  No

If yes, list. \_\_\_\_\_

Has your child had any injuries and/or operations during the past year?  Yes  No

If yes, list type and dates. \_\_\_\_\_

Has your child's physical activity been restricted during the past year?  Yes  No

If yes, list reasons and duration. \_\_\_\_\_

Is your child taking any medications?  Yes  No

If yes, why? \_\_\_\_\_

Name of medication (s) and Dosage (s). \_\_\_\_\_

Has your child ever taken any sulfa drugs?  Yes  No

Has your child had adverse reactions to any drugs?  Yes  No

If yes, list drug (s) and reaction (s): \_\_\_\_\_

Date of last tetanus immunization: \_\_\_\_\_

I, the undersigned, individually and as a parent/guardian of \_\_\_\_\_ (camper) a minor, ask that he/she be admitted to participate in the sports camp sponsored by Central Washington University. I do hereby agree to release, discharge and hold harmless the State of Washington, Central Washington University, its officers, agents, trustees, employees and volunteers from any and all liabilities, claims, costs, expenses, injuries and or/losses, that I or my minor child may sustain as a result of my minor's attendance at the sport camp or in the course of competition and/or activities held in connection with the sport camp. I hereby give consent for medical treatment and agree to assume all responsibility for payment of medical bills and expenses. Furthermore, I will be responsible for filing all claims with all insurance companies. You have my permission to release a copy of this form and the personal insurance information below to any medical provider treating my child. I also give permission for my child's photograph to appear in promotional material regarding future camps.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_, 2010

Emergency Contact Person \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: Work (\_\_\_\_) \_\_\_\_\_ Address \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_\_ State/City/Zip Code \_\_\_\_\_

Family Physician \_\_\_\_\_ Medical Insurance \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Name of Insured \_\_\_\_\_

Policy/Group # \_\_\_\_\_

