BEN VANDERKLOK GOALTENDING SUMMER CAMPS

55 GOLDEN BLVD · WELLAND ON · L3B 1H5
PH: 615-767-6808 **EM**: Bvg.lessons@hotmail.com **WEB**: www.bvgoaltending.ca

STUDENTS FULL NAME: _____

PARENTS/GAURDIANS NAMES: _____

DATE OF BIRTH: ____/____/____ **GENDER: male / female** **YEARS EXPERIENCE:**_____
mm dd year

2018/2019 LEVEL OF PLAY: _____

ADDRESS: _____
street name city prov/state postal/zip

PARENTS EMAIL: _____

HOME PHONE: _____ **CELL/WORK:** _____
Please indicate preferred contact number

SELECT DESIRED CAMP:

ELITE PROSPECTS	SUPERIOR PROSPECTS	COTK PROSPECTS
Goaltenders Born in 2007 and younger	**Goaltenders Born in (A) 2003 & 2004 AND (B) 2005 & 2006**	**** APPLICATION PROCESS ONLY**** **Please email for application**
DATE: July 2nd – July 6th	**DATE**: July 8th – July 12th	**DATE**: July 15th – July 19th
TIME: 8:00 AM – 3:30 PM	**TIME**: 8:00 AM – 3:30 PM	**TIME**: 3:15 PM – 10:30 PM
PLACE: Seymour Hannah Center in St.Catharines	**PLACE**: Seymour Hannah Center in St.Catharines	**PLACE**: Seymour Hannah Center in St.Catharines
COST: $606.20 + HST ($685.00 CAN)	**COST**: $678.00 + HST ($765.00 CAN)	**COST**: $707.10 + HST ($799.00 CAN)

Complete all documents in the Registration Package; along with a **$200.00 e-transfer deposit to:** **BVG.LESSONS@HOTMAIL.COM** **PASSCODE: BVG**

*Deposits are due April 1, 2019. The balance of payment is due June 1, 2019.. PLEASE NOTE, IF FULL PAYMENT IS NOT RECEIVED BY JUNE 1ST YOU WILL BE REQUIRED TO RE-REGISTER.

REFUND POLICY:
Your $200 deposit is non-refundable and non-transferable. All other fees will be refunded up to 1 week (7 days) prior to the day camp begins with a written Doctors medical note. After that point 80 % of the "other fees" will be refunded with notification prior to the day camp begins.
***There is no refund of any of these fees if a goaltender should drop out of the camp due to injury, illness, or for any other reason the day camp begins and after. Should the goaltender be asked to leave the camp by the director because of improper conduct, etc., no refund will be made.* _____*PARENT/GAURDIAN INITIAL*

PARENTS/GUARDIAN SIGNATURE: _____ **DATE:**_____

****CAMP ITINIERARIES WILL BE EMAILED OUT PRIOR TO CAMP. PLEASE BE SURE TO LEAVE AN UP TO DATE EMAIL ADDRESS****

2019 MEDICAL TREATMENT AUTHORIZATION

PLEASE MAIL WITH YOUR REGISTRATION FORM

Please complete this entire form, as it is necessary to ensure proper medical care for each student. When older participants are seen for minor illness or injuries, they are encouraged to inform their parents themselves. However, with younger students in almost every instance o
r with older participants with more serious problems, the physician or staff will contact parents to inform them of the problem and discuss treatment. Occasionally, we are unable to reach parents immediately. The parents signature on this medical treatment authorization form allows for treatment in these circumstances.

CAMP PROGRAM(S) ATTENDNING: _____

PERSONAL INFORMATION

STUDENTS FULL NAME: _____

DATE OF BIRTH: _____/___/___ **GENDER: male / female**
mm dd year

ADDRESS: _____
street name city prov/state postal/zip

PARENTS EMAIL: _____

HOME PHONE: _____ **CELL/WORK:** _____

IN CASE OF EMERGENCY NOTIFY: (name of parent or contact and relationship): _____

HOME PHONE: _____ **CELL:** _____ **WORK:** _____

HEALTH CARD NUMBER: _____

ALTERNATE CONTACT:

(name of contact and relationship): _____

HOME PHONE: _____ **CELL:** _____ **WORK:** _____

FAMILY PHYSCIAN: _____ **PHONE:** _____

MEDICAL BACKGROUND:

Please provide any pertinent information regarding your child's current medical health, past history, and/or medications taken that may help us better coach your child and can assist medical staff should an emergency occur.
If no medical current conditions are known, please initial: _____ (PARENT/GAURDIAN INITIAL)

_____

_____

_____

LIST ANY MEDICATIONS BEING TAKEN AND INCLUDE DOSE AND FREQUENCY.

HAVE YOU EVER HAD ANY OF THE FOLLOWING: (PLEASE CHECK)

◯ Asthma ◯ Epilepsy ◯ Diabetes ◯ Bleeding disorder ◯ Heart condition

ALLERGIES: _____

INSURANCE INFORMATION : Outside of Canada – Please attach Primary Medical Insurance / Dental Insurance information.

2019 MEDICAL TREATMENT AUTHORIZATION AND LIABILITY RELEASE FORM

I, the undersigned _____ acknowledge that I am the parent or guardian of _____, and do hereby grant my permission for my hockey player to attend a Ben Vanderklok Goaltending Camp, and to actively and fully participate in all activities thereof. In the event of an injury or illness during these activities, my signature indicates that I agree to allow medical treatment even if I cannot be contacted, and authorize Ben Vanderklok Goaltending and/or the local hospital to provide the needed medical treatment they deem necessary. I hereby release Ben Vanderklok and all members of the program's staff, the host ice facility and it's staff, the local hospital and their doctors, agents, employees, and representatives, and all officers of Ben Vanderklok Goaltending from any and all claims and liability arising in any way out of its exercise of this authority. I understand and agree that all bills for any medical/dental care and treatment will be forwarded to me, or my insurance company, and that it will be my responsibility to see that such bills are paid. I further acknowledge, understand, and agree that in participating in this activity there is a possibility of physical illness or injury and that I, as parent or guardian of my hockey player, am assuming the risk of such injury by his/her participation and release Ben Vanderklok, the program's staff, the Host Ice Rink and it's staff, and all affiliated with or participating in the Ben Vanderklok Goaltending Camps, from all liability, claims, obligations or responsibility for personal property losses, accidents or injuries of any kind. I understand the inherent risks of the training process for being a hockey player and recognize that the program is strenuous. I understand the activities that are carried out during the camp. I understand that full, legal equipment is to be worn properly at all times on ice or on the bench. I know that this camp is NOT affiliated with the Nashville Predators. I further authorize the program staff to administer non-prescription analgesics for minor medical problems such as headaches, etc. unless I have requested otherwise.

Parent / guardian signature and relationship:

_____

Hockey player's signature: _____

Date: _____