

UW-FOX VALLEY MEN'S BASKETBALL PARENT – CHILD CLINICS

<u>Date</u>	<u>Grade Level</u>	<u>Time</u>
Sunday November 1, 2009	Kind. – 1 st Grade	1:00pm-2:30pm
Saturday November 14, 2009	Kind. – 1 st Grade	1:00pm-2:30pm
Sunday November 15, 2009	2 nd Grade – 3 rd Grade	1:00pm-2:30pm
Sunday November 22, 2009	2 nd Grade – 3 rd Grade	1:00pm-2:30pm
Sunday December 6, 2009	Kind. – 1 st Grade	1:00pm-2:30pm

Cost: \$15 for one child and one parent (each additional child and/or parent only \$5)

- | | |
|---|---|
| ** Dribbling Drills and Technique | ** Passing Drills and Technique |
| ** Shooting Lay-ups | ** Shooting Technique (jump shots) |
| ** Offensive and Defensive Footwork | ** Age-appropriate games |
| ** All participants will have a basketball in their hands | ** Learn skills with your son and/or daughter |

Send To: Lee Rabas – 1615 N. Lilas Drive – Appleton, WI 54914

Check Payable To: UW-Fox Valley Men's Basketball www.uwfoxbasketball.blogspot.com

Cut Here ===== Return Bottom Portion With Payment ===== Cut Here

(Check Clinic(s) You Will Be Attending)

November 1st _____ November 14th _____ November 15th _____ November 22nd _____ December 6th _____

Name: _____ Grade: _____ School: _____

Address: _____ City: _____ Zip: _____

Parent/Guardian: _____ Phone: _____

E-mail: _____ Parent/Guardian Attending: _____

Health and Medical Information / Liability Waiver

Participant's Name _____ Birthdate _____ Physician _____

I certify that this student/person is in good physical condition and is physically able to participate in basketball clinic, basketball skill, and basketball related drills and activities. Also, I hereby authorize the directors of the camp to act for me according to their best judgement in any emergency requiring medical attention. Furthermore, I hereby waive and release UW-Fox Valley, the UW-Fox Valley athletic department, the UW-Fox Valley men's basketball program, and the UW-Fox Valley Parent-Child clinic (its directors, coaches, and workers) from any and all liability for any injuries incurred while attending the parent-child clinic.

Please note any medical conditions that we should be aware of (attach an additional sheet if necessary):

Date _____ Signature of Parent, Guardian, or Doctor _____

Insurance Information

Each must be covered by his or her own family insurance.

The name of our insurance company is _____

The number of our policy is _____ Signature of parent or guardian _____