Welcome to the Game On Camps!

We are glad that you chose the Game On Camp experience- the countdown is on!
All details and information may be found on www.gameoncampsandclinics.com.
This packet includes all the details that you will need to know for camp including: transportation, registration, check-out, commuter policy, what to bring, daily schedule, and health forms.

TO DO BEFORE CAMP:

✔ Email gameoncamps@gmail.com if you are arriving by plane and will be taking the airport shuttle (not through the camp). Send your: Arrival time, airline and flight number, cell phone number AND your departure time and flight number
✔ Make sure you have everything you need on the "what to bring list."
✔ Print out and complete the health form, insurance form, and parental release form. You will need a Physician's signature. Mail all completed forms to Game On Camps & Clinics, PO Box 668, Storrs, CT 06268 or scan and send them to gameoncamps@gmail.com.

REGISTRATION CHECK LIST:

✔ Signed Parental Release Form by parent or guardian
✔ Signed Health Form by physician.
✔ Balance Due
✔ Excitement for camp!

CONTACT INFORMATION:

Website: http://www.gameoncampsandclinics.com
Mailing Address: PO Box 668, Storrs, CT 06268
Email: gameoncamps@gmail.com
Phone: 860-214-1091

CAMP MISSION:

Want to take your game to the next level? Game On Camps will help you get there! When you're competing, you work harder, take more risks, and play out of your comfort zone. At our camps, we teach college level lacrosse and encourage risk taking! There is a competitive element to each session allowing the campers to see their progress and get their GAME ON!

CAMP DIRECTOR:

Katie Woods, UConn Head Coach

CAMP STAFF:

The camp staff will include the University of Connecticut Staff, college coaches from around the country, and current University of Connecticut players. After March 1, a complete staff list will be available online.

CANCELLATION POLICY:

All requests for cancellations must be sent in writing through email. All monies will be refunded, except for a $200.00 processing fee, provided cancellation arrives at least two weeks prior to the start of camp. No refunds will be given less than two weeks before the start of camp.

MEDICAL CARE:

A certified athletic trainer will be on hand to assist with taping and minor injuries. You should come to camp ready to participate in all sessions and games. Emergency medical facilities are nearby. Included in the camp confirmation packet is a health form that must be signed by a physician prior to the start of camp. You can download this form at www.gameoncampsandclinics.com.

FEE:
Fee Includes: Room and Board, meals, instruction, t-shirt and shorts.
If you lose your Room Key, you will be charged $100.

FACILITIES:
The Game On Overnight Camp will be held at The University of Connecticut. Campers will stay and dine in the UConn dormitories. All floors will have adult supervision. Campers will play on field turf and astroturf.

COMMUTER POLICY:
Drop off and pick up will be located at the dorms (given at registration) Drop off time is 8:15 am. Pick up time is 8:30 pm. Commuters will be provided lunch and dinner. We will also have a commuter lounge where they can hang out during breaks. All commuters must check in and out with camp staff every morning and night.

REGISTRATION INFORMATION:
Registration will be held at the dorms. You will receive an email prior to camp with detailed information on registration times and location.

CHECK OUT INFORMATION:
Check out will be from 11:30am on the final day of camp. Check out will be located at the dormitory.

WHAT TO BRING:
Lacrosse Stick
Goggles
Mouthguard
Pinnie
Cleats
Sneakers/ Turf Shoes
Plenty of t-shirts
Shorts
Socks
Money for the Camp Store to purchase snacks, pizza, and GEAR!
Towel
Toiletries
SUNBLOCK
Bedding for dorm
Fan (for the room)

FORMS:

PLEASE MAIL ALL FORMS TO:
Game On Camps & Clinics
PO Box 668

Storrs, CT 06268

OR EMAIL TO:
gameoncamps@gmail.com

CAMP WAIVER

Waiver Statement

All participants must have their own medical coverage. The school provides excess coverage after your insurance policy has been utilized. Participation will not be allowed unless proper medical insurance information is submitted in the "Medical Insurance Form" and the "Waiver Statement" is signed by the parent or legal guardian of the participant.
I/We, the undersigned, for ourselves, our heirs, executors, and administrators agree to hold Game On Camps & Clinics, the University of Connecticut, the directors of Game On Camps & Clinics and all coaches, clinicians, staff, agents, representatives, employees, successors, and assigns harmless from any injury my daughter may incur while involved with any camp activities and waive, release and forever discharge all named from any and all rights and claims for damages to person and property activities while participating in camp activities or resulting from camp activities. I/We understand that this is an independent camp and in no way is affiliated or sponsored by any university. My daughter is physically fit to take part in lacrosse and camp-related activities. I/We hereby give Game On Camps & Clinics directors, coaches, training staff, and emergency personnel permission to render such medical and hospital care that in their judgment necessary for my daughter in the event of an injury, illness, or accident. I/We agree to bear the cost of any treatment such performed.

_____ _____

Participant's Signature
(if 18 years of age or older)

Date

_____

Parent/Legal Guardian Signature

HEALTH FORMS

YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF
Physical Exams Are Valid For 3 Years
From Date of Last Examination

☐Camper ***Please Return Completed Form to Camp***

❑Staff

Name _____ Date of Birth _____ Phone_____
Guardian_____ Address_____
Emergency Contact _____ Telephone_____
Date of Arrival at Camp: _____ Departure Date:_____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam_____

_____ May participate in all camp activities
_____ May participate except for: _____
_____

Medical information pertinent to routine care and emergencies:
Is this individual taking prescription medication? YES NO
If yes, indicate prescription: _____
Does the individual have allergies? YES NO Explain:
Is the individual on a special diet? YES NO Explain:
This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American

Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

Comments:

_____

_____

Print name of medical care provider: _____
Medical care provider's address: _____
Medical care provider's: City/Town_____ST_____Zip Code_____

_____
Signature of Physician, APRN or PA

_____
Date Form Signed

_____
Telephone Number

Game On Camps & Clinics, LLC
PO BOX 668
STORRS, CT 06268

STATE PROCEDURES REGARDING MEDICATIONS:

Campers must surrender all medication, EVEN OVER-THE-COUNTER MEDICATION (i.e. Tylenol, Advil, etc) to our Medical Staff at check-in, to be placed in a locked medical box for the duration of the camp. Campers may self-administer medications when needed with documented parental and authorized prescriber permission. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber or dentist's name and date of the original prescription. Over-the-counter medication must be in the original container and labeled with the child's name.

Date:_____

I hereby request that the following medication be self-administered by my daughter, _____, for the camp week of _____.
(PLEASE PRINT CAMPERS NAME) **(MONTH, DATE, YEAR)**

I understand that I must supply the youth camp with the prescribed medication in its original container and properly labeled by a physician/pharmacist. Over the counter medication shall be labeled with the child's name by the Parent/Guardian(s) at check-in.
I understand that this medication will be destroyed if not picked up within (1) week following the end of this session of camp.

Name of Medication:_____
Times of Administration:____, ____, ____ Shall be administered from ___/___/___ to ___/___/___
Is this a controlled drug?_____

Authorized prescriber's or Dentist Name (PRINT):_____ Phone #:_____

Street Address_____ City/Town_____ State_____

Authorized Prescriber or Dentist Signature_____

Parent/Guardian(s) Name (Printed):_____

Parent/Guardian(s) Signature:_____

Relationship to child:_____

Phone Number:_____

Name of Child:_____ Room #:_____ Skill Group:_____ Pharmacy Name_____ Prescription #_____

Medication Name:_____

Date:__/__/__ Time:_____ AM/PM Dosage:_____ Strength:_____ Trainer:_____
Comments:_____
_____
_____

Medication Name:_____

Date:__/__/__ Time:_____ AM/PM Dosage:_____ Strength:_____ Trainer:_____
Comments:_____
_____
_____

Medication Name:_____

Date:__/__/__ Time:_____ AM/PM Dosage:_____ Strength:_____ Trainer:_____
Comments:_____
_____
_____

Medication Name:_____

Date:__/__/__ Time:_____ AM/PM Dosage:_____ Strength:_____ Trainer:_____
Comments:_____
_____
_____

Medication Name:_____

Date:__/__/__ Time:_____ AM/PM Dosage:_____ Strength:_____ Trainer:_____

Comments:_____
_____
_____

Medication Name:_____

Date:__/__/__ Time:_____ AM/PM Dosage:_____ Strength:_____ Trainer:_____
Comments:_____
_____
_____

Medical Insurance Form

Participant Name: _____

Subscriber Name: _____

Insurance Company: _____

Policy Number: _____

Parent Signature: _____ Date: _____