



# WINTER INDOOR LACROSSE CLINIC



**HELD AT STONINGTON  
HIGH SCHOOL**

**FOR BOYS AND GIRLS!  
U9, U11, U13, U15**

**Held in conjunction with the Stonington Seals and Stonington Parks and Rec.**

- Lacrosse Conditioning, Skills and Drills.
- Progression Based Structure to increase the skill level of drills for each session.
- Position Specific Training.
- Major focus on teaching the proper mechanics and fundamentals of the game of Lacrosse.
- Mastering Stick Skills.
- Shooting/ Dodging/ Defensive Footwork/ Goalie Training/ Face-off.
- Enhance your overall skill level as a Lacrosse Player.
- Speed and conditioning Training to prepare for the Spring Season.
- **Equipment needed for Boys:** Helmet, mouth guard, shoulder pads, elbow pads, gloves & stick.
- **Equipment needed for Girls:** Goggles, mouth guard, and stick.



<http://blackwolves.com/>

**Special guest  
presenters from  
NE Black Wolves  
& Conn. College  
Dates TBD**

**8-week Session, held Saturdays  
Jan 17-March 14 (no clinic Feb 14)**



-  **Girls U13 & U15:** 2:30-3:30 PM (main gym)
-  **Girls U9 & U11:** 3:30-4:30 PM (aux gym)
-  **Boys U9 & U11:** 2:30-3:30 PM (aux gym)
-  **Boys U13 & U15:** 3:30-4:30 PM (main gym)



<http://camelathletics.com/>

**Fee:** \$10 Resident / \$20 Non Res

**To Register:** complete attached form and send to  
Stonington Human Services Recreation Division

**Winter 2015**

[www.stonington-ct.gov](http://www.stonington-ct.gov)  
[www.stoningtonsealslacrosse.org](http://www.stoningtonsealslacrosse.org)



166 South Broad Street – Pawcatuck, CT 06379  
(860) 535-5015 - Phone  
(860) 599-8290 - Fax  
[www.stonington-ct.gov](http://www.stonington-ct.gov)

## Youth Program Registration

Program(s): \_\_\_\_\_

How did you hear about our program? \_\_\_\_\_

### Child

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Birthday: \_\_\_\_\_ Gender: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Grade: \_\_\_\_\_ School: \_\_\_\_\_  
(Current grade OR for summer programs, grade entering in Fall)

Child Lives With: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Parent(s)/Guardian(s)

Name: \_\_\_\_\_ Primary Contact #: \_\_\_\_\_

Workplace: \_\_\_\_\_ Work# \_\_\_\_\_ Cell#: \_\_\_\_\_

Would you like to receive email notices? \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Primary Contact #: \_\_\_\_\_

Workplace: \_\_\_\_\_ Work# \_\_\_\_\_ Cell#: \_\_\_\_\_

Would you like to receive email notices? \_\_\_\_\_ Email: \_\_\_\_\_

If child's parents legally separated or divorced, who is the custodial parent? \_\_\_\_\_

If sole custody, please note any special considerations regarding child(ren): \_\_\_\_\_

### Emergency Contacts

*Please provide at least two emergency contacts, with valid phone numbers, who are authorized to pick up your child:*

<u>Name</u>	<u>Address</u>	<u>Phone</u>	<u>Relationship to Child</u>
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1.) \_\_\_\_\_

2.) \_\_\_\_\_

3.) \_\_\_\_\_

4.) \_\_\_\_\_

Please complete next page



### Health

Health Insurance: Yes \_\_\_ No \_\_\_ Plan: \_\_\_\_\_

Child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications\*: \_\_\_\_\_

Physical Limitations: \_\_\_\_\_

Special Behavior Considerations: \_\_\_\_\_

Developmental Considerations: \_\_\_\_\_

Does your child have an IEP? \_\_\_\_\_ *If yes, please call (860) 535-5015 to arrange for a support plan to ensure your child's success within Stonington Human Services programming.*

\*Please return completed medication self-administration form

*Stonington Human Services is required by the Connecticut State Department of Education to report statistical data of participants in our programs. Your child/children's name(s) will not be released or publicized in any way. This required information is for state funding purposes only. The state received numerical information only.*

*Your child may be given anonymous surveys related to the quality and content of Stonington Human Services youth programming.*

*Stonington Human Services reserves the right to take photographs to be used in publications for the Department.*

*This is to certify that I have read and understand this waiver, hold harmless agreement, and release of liability, and consent and agree to the release set forth above, and for myself, my heirs, assigns, successors, executors, administrators, and legal representatives, agree to defend, indemnify, and hold harmless the Town of Stonington and its agents, servants, or employees, from any and all claims, suits, or demands by anyone arising from said participants in programming including claims of negligence on the part of the Town of Stonington and its agents, servants or employees.*

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**Forms should be returned, with payment, to:** Stonington Human Services, 166 South Broad Street. Pawcatuck, CT 06379. Office Hours: Monday-Friday, 9:00AM-4:30PM. Forms may be placed, with payment, in the lockbox located on the Human Services building, to the left of the entrance. Checks can be made payable to *Stonington Human Services*. Credit cards are accepted, however a convenience fee applies.

#### REFUND POLICY:

Refunds will be granted in full if notification is given to the Department of Human Services **2 weeks** prior to the first day the program starts. Exceptions will be made if there is a waiting list for a program/trip. A full refund or credit will be granted if Stonington Human Services cancels a program.