



St. Raphael Golf Program 2012

Participants: Students presently in grades 4 – 8 (must be 10 yrs. old by start date)

Location: Bob-O-Links Golf Course

When: Thursdays, June 14 – July 19 11 a.m.-3 p.m.

What: Lessons followed by nine holes of golf

Cost: \$115 (At the end of the program, each student receives a card to golf for the remainder of the season FREE at Bob-O-Links)

Registration forms will be available online only.
Mail to: Patti Nugent, 1419 Adelaide, Westlake, OH 44145.

Registration will close when either the enrollment maximum of 80 participants is reached **or** by **May 18**, whichever comes first.

A student is registered once all three of the following items are received:

Registration Form

Emergency Authorization Form

Check (payable to Bob-O-Links Golf Course)

(Any questions may be directed to Patti Nugent at nubried@att.net or 440-617-0197.)

St. Raphael Summer Golf Program 2012

Registration Form

Registration will close when either the enrollment maximum of 80 participants is reached *or* by **May 18th**, whichever comes first.

PLAYER NAME: _____ TELEPHONE: () _____

ADDRESS: _____ CITY/ZIP: _____

BIRTH DATE*: _____ / _____ / _____ CURRENT GRADE: 4 5 6 7 8

***Student MUST be 10 years old by start of program.**

This is a requirement of the course.

School: _____ ATTENDING PSR? Yes No

Parent's Names: _____

Parent(s) Cell Phone Number(s): _____

Primary Email Address for Parents (please write legibly): _____

I, the undersigned, parent of _____ do hereby consent to permit my child to engage in the sport of golf in the 2012 summer season. Further, I, as parent and natural guardian of my minor child, and on his/her behalf, agree that neither the manager, the coach, the parish, the pastor or the Bishop of Cleveland shall be in any way legally responsible for the cost of any treatment or hospitalization or any medical expenses arising out of any injury received by my child while engaged in lessons or in course play. I further agree to save hold harmless, and indemnify, any manager, coach, parish, pastor or Bishop of Cleveland from any and all claims for damages sustained by my child arising out of his/her participation in this sport. I further agree that my child will have an annual physical examination from a physician before the child participates in any athletic activity. I understand that my child must be a parishioner of Saint Raphael parish and must currently attend St. Raphael School or currently attending a PSR class.
No refunds after May 31st.

PARENT SIGNATURE: _____ DATE: _____

Cost: \$115 per student. (Checks payable to Bob – O – Links.)

Mail to: Patti Nugent, 1419 Adelaide Street, Westlake, OH 44145

If you have any questions, contact Patti Nugent at nubried@att.net or 440-617-0197.

EMERGENCY MEDICAL AUTHORIZATION

Student Name / Birth Date

Address

Telephone

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

**PART I OR II MUST BE COMPLETED
PART I TO CONSENT**

In the event reasonable attempts to contact me at _____ (phone number) or _____ (other parent or guardian) at _____ (phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (Preferred Dentist, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to _____ (preferred hospital) or any hospital reasonably accessible.

The authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted _____

Date

Signature of parent or guardian

Address

**DO NOT COMPLETE PART II IF YOU COMPLETED PART I
PART II REFUSAL TO CONSENT**

I do not give my consent for emergency medical treatment of my child, in the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

Date

Signature of parent or Guardian

Address