

SLINGER BASKETBALL

2024 Summer Basketball Academy

JUNE 12th, 17th, 19th, 24th, 26th
JULY 8th, 10th, 15th, 17th

Participants will receive instruction from Coach Lavine and the high school basketball staff. The camp instruction will focus on shooting, offensive footwork, ball handling, and scoring.

GRADES 4th-5th

CODE: 5339

LOCATION: Addison Elementary

TIME: 8:30-10:00 am

Camp Leader: Coach Alex Lavine

GRADES 6th-7th

CODE: 5340

LOCATION: Addison Elementary

TIME: 10:45 am-12:15 pm

Camp Leader: Coach Tony Dobson

GRADES 8th-12th

CODE: 5341

LOCATION:

Slinger High School Gym

TIME: 6:45-8:00 am

Camp Leader: Coach Alex Lavine

FEE | \$125 per participant

**No partial payments accepted*

- *Participants should bring their own basketball –*
- *Participation at all camp dates is encouraged, but not required –*

2024 Slinger Boys Basketball Academy Camp

Circle *T SHIRT SIZE: **YS - YM - YL - AS - AM - AL - AXL**

NAME _____ HOME PHONE _____ CODE# _____

PARENT'S NAMES _____ ALTERNATE / CELL PHONE _____

ADDRESS _____ CITY _____ ZIP _____

BIRTH DATE ____/____/____ AGE _____ ENTERING GRADE _____

EMAIL ADDRESS: _____

Are there any medical conditions we should be aware of? Yes ___ No ___

Comment _____

Make checks payable to the "SLINGER PARKS & RECREATION DEPT."

LIABILITY WAIVER & PARENT CONCUSSION AGREEMENT FORM:

As a Parent and as an Athlete it is important to recognize the signs, symptoms, and behaviors of concussions. By signing this form you are stating that you understand the importance of recognizing and responding to the signs, symptoms, and behaviors of a concussion or head injury. This form must be completed for every sports season and every youth athletic organization the athletes are involved with. All concussion safety information is posted on the Slinger Recreation Department Website at www.vi.slinger.wi.gov. It is your responsibility as a parent to read this information carefully before signing this waiver.

PARENT AGREEMENT:

I _____ have read the Parent Concussion and Head injury information and understand what a concussion is and how it may be caused. I also understand the common signs, symptoms, and behaviors. I agree that my child must be removed from practice/play if a concussion is suspected.

I understand that it is my responsibility to seek medical treatment if a suspected concussion is reported to me.

I understand that my child cannot return to practice/play until providing written clearance from an appropriate health care provider to his/her coach and to our department.

I understand the possible consequences of my child returning to practice / play too soon.

Parent / Guardian Signature: _____ **Date:** _____