COQUILLE INDIAN TRIBE SOUTHWESTERN OREGON YOUTH GOLF CLINIC

BANDON DUNES GOLF CLINIC FORMAT

DATE:	Thursday July 7th, 2011
LOCATION:	Bandon Dunes Practice Center
PARTICIPANTS:	Approximately 120 youth
AGE:	7 - 18 years (entering 2nd grade to 12th grade next year)

GROUP ONE:

Ages 12 – 18

12:30pm – 4:30pm

GROUP TWO:

Ages 7 – 11

2:30pm – 4:30pm

Group one (ages 12-18)

12:30 – 1:00 p.m.	CHECK-IN
1:00 – 1:15 p.m.	Clinic Coordinator - Explain Groups Introduction of Clinic Teaching Staff Stretching/Warm-up
1:15 p.m.	First Station Putting
1:45 p.m.	Change Stations Chipping
2:15 p.m.	Change Stations Full Swing
2:45 - 4:00 p.m.	Mini Course
4:30 - 4:45 P.M	Closing Remarks

Group two (ages 7-11)

2:30 p.m.	CHECK-IN
2:45 – 3:00 p.m.	Clinic Coordinator - Explain Groups Introduction of Clinic Teaching Staff Stretching/Warm-up
3:00 – 3:30 p.m.	First Station Putting
3:30 – 4:00 p.m.	Change Stations Chipping
4:00 – 4:30 p.m.	Change Stations Full Swing
4:30-4:45 P.M	Closing Remarks

PLEASE PICK YOUR CHILD UP NO LATER THAN 4:45 P.M.

Any questions contact
Luke or Jane 541-888-9494

CC000217
2011 Youth Golf Sign Up Form

PERMISSION FOR ACTIVITY - MEDICAL INFORMATION AND RELEASE FORM

(A separate form must be completed for each participant)

I give permission for my child to **attend Southwestern Oregon Youth Golf Clinic** to be held at **Bandon Dunes Golf Resort Practice Center in Bandon, Oregon** on **THURSDAY, JULY 7th, 2011**

~ ~ AGE _______ ~ ~

I hereby release the Coquille Indian Tribe and/or any sponsoring entity from any and all liability for any event or consequences whatsoever in any way arising out of, or relating to the applicant's entry or participation in this summer golf clinic. In case of an emergency occurring during this camp I authorize a qualified medical doctor to take all necessary measures in the treatment of this applicant.

In the event that my child leaves the activity on his/her own accord and that staff cannot find him/her, the staff will contact one of my designated emergency contacts or me immediately.

My child's name is: ____________________________________Age: ______________________

Address: ____

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Day Phone #: ______________________**Evening Phone #:** ______________________________

Allergies: ____

____

Emergency Contacts:

Name: ____Phone: ________________________

Name: ____Phone: ________________________

Physician's Name: ________________________________ Phone: ________________________

Physician's Address: ____

Signature of parent or guardian: ________________________________ Date: _______________

Please mail your signed Activity Release Form to:

The Coquille Indian Tribe Community Center, P.O. Box 3190, Coos Bay, OR 97420 or drop it off at **591 Miluk Drive, Coos Bay, OR** **before July 1st, 2011.**

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