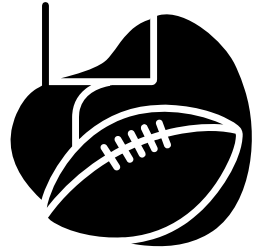




C.B. WEST 2011

YOUTH FOOTBALL CAMP



TWO different sessions offered!

Cost: \$150/session (All campers receive an official camp T-shirt).

Dates: Session I: June 27 – June 30 Ages: 7-15

Session II: July 11 – July 14 Ages: 7-15

Times: 9:00 AM – 3:00 PM

An Early Drop-off (8:00 AM) and Late Pick-Up (4:00 PM) program is available for each camp session for an additional \$40 fee per week.

Location: C.B. West Athletic Fields & Gyms

Skills Covered:

- Proper Stances for all Positions
- Proper Form Running
- Cadence
- Alignments by Position
- Form Blocking Techniques
- Safe Tackling Techniques (non-contact)
- Ball Carrying and Receiving
- Throwing Mechanics
- Snapping, Punting, and Place Kicking
- **HAVING FUN!**

The camp is run by the coaches and players of the C.B. West Football Program and designed to teach fundamentals from beginner through advanced youth football players.

Registration begins February 25th.

Please complete the reverse side of this form and return with check payable to:

"Central Bucks Community School"

C.B. West Football Club
Central Bucks High School – West
375 W. Court Street
Doylestown, PA 18901

Questions – call or email Coach Brian Hensel: 267-893-2535

bhensel@cbsd.org

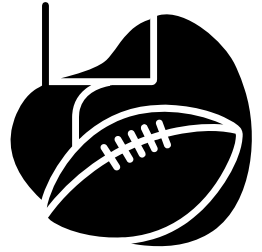
<http://www.cbwestfootball.com>

Space is LIMITED! Camper spots will be filled on a first come, first served basis.



C.B. WEST 2011

YOUTH FOOTBALL CAMP



Child's Name: _____ Age: ____ (as of 7/1/11)
(Please print)

Current School: _____ Current Grade: _____

Session I (6/27 - 6/30) _____ Session II (7/11 - 7/14) _____ Extended Day Care (add'l \$40) _____

T-Shirt Size: Youth-M Youth-L Adult-S Adult-M Adult-L Adult-XL
(Circle one, please)

Parent Email: _____
(Camp Updates & Announcements) (Please print)

OPTIONAL:

Offensive Pos. 1st: _____ 2nd: _____ Defensive Pos. 1st: _____ 2nd: _____ Kicking Pos. 1st: _____ 2nd: _____
(Ex. QB, RB, WR, OL, TE) (Ex. DB, LB, DL) (Ex. Kick, Punt, Return, Snap, Hold)

CENTRAL BUCKS SCHOOL DISTRICT – DOYLESTOWN, PA

PERMISSION FOR MEDICAL TREATMENT

In the event of an emergency requiring medical attention, I hereby grant permission to a physician or other hospital personnel designated by the Central Bucks School District to attend to my son/daughter:

Child's Name: _____ Age: _____ (as of 7/1/2011)

I expect every effort will be made to contact me in order to receive my specific authorization before any treatment or hospitalization is undertaken.

Parent Signature: _____ Home Phone: _____

Home Address: _____ Work Phone: _____
(Number and Street)

_____ Cell Phone: _____
(Town, State, Zip Code)

If parents **CANNOT** be reached, then call:

Family Doctor: _____

Phone #: _____