

# Summer Wrestling Camp 2008

At

**Clinton Rosette Middle School**

June 16<sup>th</sup> - 19<sup>th</sup>

**K - 8<sup>th</sup> Grade**



## Time Schedule

9:30 a.m. - 12:00 p.m.

## Cost

\$50.00 to District 428 Students

\$60.00 Non-Dist 428 Students

## Where

Clinton Rosette Middle School (650 N. 1<sup>st</sup> St.)

(Enter through front door and follow signs)

## Staff

Dan Weller and Pat Kiley (Coordinators) and  
DeKalb Jr. High Coaches and High School Wrestlers

## Camp Overview

Folk style Free style

Stance/Takedowns—Escapes/Reversals—Turns—Legs and More

## Send Registration To

Dan Weller, 329 knollwood DeKalb IL 60115  
please Make All Checks Payable to: Dan Weller

Any questions please contact Dan Weller 762-6926 (email: [dan.weller@dist428.org](mailto:dan.weller@dist428.org))

**THIS CAMP IS FOR ALL LEVELS, BEGINNERS TO EXPERIENCED**

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
School \_\_\_\_\_ Emergency Phone \_\_\_\_\_  
Approximate Weight \_\_\_\_\_ Age \_\_\_\_\_ Years Experience With Club/School \_\_\_\_\_  
T-Shirt Size \_\_\_\_\_ Email: \_\_\_\_\_

### Consent For Medical Treatment of A Minor

I, \_\_\_\_\_, declare that I am the \_\_\_\_\_ (ie. Mother) of  
\_\_\_\_\_. I understand that should a major medical problem arise, an attempt will be made to  
notify me by phone. In the event that I cannot be reached, I hereby give my consent to such treatment as deemed necessary, including  
surgery, x-ray exams, and anesthesia to be rendered to said minor by a licensed physician or nurse. The directors of the DeKalb  
Wrestling Camp may act for me according to their best judgement in any emergency requiring medical attention. I also release the  
camp and District 428 of any liability for any injuries incurred while at camp or traveling to or from camp.

I have read and understand this authorization. \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_