

COQUILLE INDIAN TRIBE SOUTHWESTERN OREGON YOUTH GOLF CLINIC

BANDON DUNES GOLF CLINIC FORMAT

DATE: Thursday July 15th, 2010
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.

Coquille Indian Tribe
Southwestern Oregon
Youth Golf Clinic
Sponsored By
The Coquille Indian Tribe
Community Center & Bandon Dunes



**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 15th, 2010

~~ 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: _____

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 9th, 2010.**