GAME BREAKER® LACROSSE CAMPS

2025 Confirmation Packet

Wheaton College
Norton, MA

Girls: June 23 - 25 | Boys July 28 - 30

Dear Parents,
Thank you for registering for our 2025 GameBreaker Lacrosse Clinic! We hope that this clinic will be an unforgettable and exciting opportunity for your athlete to improve his or her skills and work with some of the top coaches and players in the game!

This packet is designed to help you prepare for your upcoming clinic Please read this entire packet carefully, as it contains all the forms, important information, and tips you need to set your athlete up for a smooth, successful clinic experience.

If you have any questions after reviewing this packet please feel free to contact us via email or phone at support@LaxCamps.com or 800.944.7112.

We look forward to seeing you all at clinic this summer!

Best Regards,
The GameBreaker Lacrosse Clinic Staff

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OUR MISSION

The GameBreaker Lacrosse Clinics were developed to provide young athletes with the opportunity to become better lacrosse players by providing instruction from the top coaches in a positive and fun atmosphere.

HEALTH & SAFETY

We want to ensure your child a safe and positive environment during their time at clinic athletes are expected to abide by the clinic rules and live by our core values. Drugs, alcohol and tobacco products are strictly forbidden and constitute, along with general misconduct, grounds for dismissal from clinic without a refund.

FINAL PAYMENT

Final Payments are due in our office by May 15th. Any athlete with a remaining balance will be prohibited from checking into clinic We do not accept final payments at clinic Final payments can be paid via mail, over the phone, or through your online account. If you are unsure about your balance, please call us at 800.944.7112

CANCELLATION POLICY

Any athlete who must cancel their registration more than fifteen (15) days prior to the clinic start date will receive a voucher equal to the full amount of clinic tuition already paid which may be used toward any program or clinic offered by eCamps. If a athlete must cancel their registration fourteen (14) days or fewer prior to the start of clinic, eCamps will issue athlete or Parent a voucher equal to 50% of the clinic tuition, which may be used toward any program or clinic offered by eCamps. Vouchers are valid for any eCamps program within the same or next calendar year and are also transferable to another family member. clinic vouchers are not extended to athletes who leave clinic after the start of a session. The $30 registration fee is non-refundable. ***Cash refunds are not offered under any circumstances.***

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CHECK - IN

8:45 am on the first day at the athletic fields. athletes should be dressed and ready to play upon arrival each day. Full Day athletes Must bring their own bagged lunch. We suggest that half day athletes pack a small snack.

CHECK - OUT

Pick up will be at 3:00pm each afternoon at the dropoff location for full-day athletes. Half day athletes will be picked up at 12pm.

HEALTH FORMS

Every athlete must have the attached health history and release form filled out in order to attend clinic Please upload your health forms to your active.com account before the start of clinic

*A physician's signiture is required on this form ONLY if you are attending a clinic in CT, MA or NY. An attached physicians signed physical form from within two years will suffice. clinics in CT require the 'Administration of Medication' form for any medication brought to clinic--this form can be found on LaxCamps.com

CONCUSSION INFORMATION FOR PARENTS

CELL PHONE POLICY

Use of phones is not permitted during the instructional blocks of clinic, including on-field and classroom sessions. We feel this will minimize distractions to the learning environment, help maintain an inclusive atmosphere and alleviate potential problems that can detract from the overall experience for everyone.

Phone use will be allowed during in the mornings prior to morning session, at lunch, and for overnight clinics before and after the evening session. We will still encourage players to minimize their time on devices in order to interact and engage with other athletes, but understand they might want the chance to call home, text friends, etc.

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CHECKLIST OF THINGS TO BRING

Below is a list of items to bring to clinic We suggest that athletes do not bring expensive personal items such as cameras, iPods/iPads, etc. Please label every article you bring to clinic All items will be the responsibility of the athlete. GameBreaker Lacrosse and its clinic staff are not responsible for lost, stolen or forgotten items.

- Health Form
- GIRLS: Lacrosse Stick, goggles
- BOYS: Lacrosse Stick Gloves, Shoulder Pads, Elbow Pads, Helmet
- Cleats, sneakers
- Mouthguard
- Lunch/Snack
- Water Bottle

athletes ARE REQUIRED to bring their own equipment

CLINIC ADDRESS

Please use the following address:

Wheaton College
26 E Main St
Norton, MA 02766

Check-in: Nordin Athletic Fields

eCamps Inc. Summer Camp Health Record

Every camper must have this health record filled out and bring it with them to camp check-in. Camps held in the following states require this form to be completed and signed by a physician before your child can participate at summer camp, (CT, MA, NY).

PLEASE DO NOT MAIL AHEAD.

Camp Attending:_____

Name:_____
Last First Middle Initial

DOB:_____ Age:_____ Sex:_____

Parent/Guardian:_____

Address:_____

Phone (Home):_____

Phone (Work):_____

Phone (Cell):_____

*Emergency Contact:*_____

*Phone (Home):*_____

*Phone (Cell):*_____

Health History

____May Participate in all camp activities

____May participate except for_____

_____

Does this individual have allergies? ☐ YES ☐ NO

Explain:_____

_____

Is this individual on a special diet? ☐ YES ☐ NO

Explain:_____

_____

Does the individual have special needs? ☐ YES ☐ NO

Explain:_____

_____

I have examined the above camper with in the past two years.

Date Examined_____

Physician's Signature_____

Physician's Name_____

Today's Date_____

Address_____

Phone _____

PLEASE NOTE: DOCTOR SIGNATURE IS ONLY REQUIRED FOR CAMPS IN CT, MA & NY

Immunization History (Please List Dates)

Copy of Immunization Record Preferable with copy of physical within the last 18 months

DPT _____ Booster_____

Meningococcal vaccine (required for grade 7-12)

_____

DT_____

Polio OPV (Sabin)_____ Booster_____

Measles/Mumps/Rubella (MMR) #1_____

#2_____ Hepatitis B #1_____ #2_____

#3_____ Chickenpox_____

Tetanus_____

Turberculin_____

Pneumococcal Conjugate_____

Haemophilus Influenza b (HIB)_____

COVID-19 #1_____ #2_____ Booster _____

Insurance Information

*Health Insurance Provider:*_____

Policy/ID Number_____

Policy Holder's Name & DOB_____

*Insurance Provider Contact: Phone*_____

Mailing Address_____

Please include a photocopy of your Health Insurance card for our records.

Parent's Authorization

This health history is correct so far as I know, and the person herein described has permission to participate in all activities except as noted.

I give my child permission to be treated by emergency response personnel. I understand that every attempt will be made to contact me, or the emergency contact, before taking this action. I hereby waive and release eCamps Inc, staff, camp management and sponsors from any liability for any injury or illness incurred while at camp. I UNDERSTAND THAT THERE IS A RISK OF INJURY TO MY CHILD AS A RESULT OF CAMP ACTIVITIES, AND KNOWINGLY AND VOLUNTARILY ASSUME ALL RISK OF SUCH INJURY. I will be financially responsible for any medical attention needed during camp.

Parent Signature_____Date_____

NOTEMedication will be checked and kept by the staff. All prescription medications must be in their original case/box with the legible prescription label; including inhalers. The "prescriber's authorization form" must accompany all medication and requires the physician's signature in CT, MA & NY.

Authorization of Self-Administration Medication Form

This form allows both the parent/guardian and the prescriber to ensure the camper is capable of self-administering the medication safely while at camp, ***If your camp requires any medication while at camp or ICE, you MUST complete this form in totality and present to first aider at check-in with medication.*** All medication MUST be brought to camp in the original container and have proper pharmacy labelling. If these conditions are not met and paperwork completed, your camper will not be allowed at camp. You MUST also complete an Individual Care Plan available on our website.

Camper Information:

- Camper's Full Name: _____
- Date of Birth _____
- Camper Address: _____
- Parent/Guardian Name: _____
- Parent/Guardian Phone Number: _____
- Parent/Guardian Email: _____

Medication Information:

- Name of Medication: _____
- Dosage: _____
- Time(s) of Administration: _____
- Condition being treated: _____
- Specific Instructions for Medication Administration: _____
- Potential Side Effects _____ None Expected ☐
- Plan to Address Potential Side Effects: _____

Parent/Guardian Authorization for Self-Administration:

☐ I, the undersigned parent/guardian, hereby authorize my child, named above, to self-administer the medication listed above while attending the summer camp program. I understand that my child has been instructed by a healthcare provider on how to properly administer this medication. I am confident in my child's ability to safely and responsibly manage this medication while at camp.

☐ I agree to provide the camp with an adequate supply of the medication, properly labeled, in accordance with camp policy. I also understand that the camp staff may provide assistance if necessary and that the camp will monitor my child's adherence to medication administration as best as possible.

Parent/Guardian Consent:

- Parent/Guardian Signature: _____
- Date: _____
- Relationship to child: _____

Prescriber's Authorization:

☐ I, the undersigned prescribing healthcare provider, authorize the child named above to self-administer the medication as described. I confirm that this child has been educated on the proper use of the medication, including potential side effects, and is capable of administering it independently while at camp. I understand that the camp staff will make reasonable accommodations for the camper's health and safety during the camp session.

- Prescriber's Full Name: _____
- Prescriber's Title: _____
- Prescriber's Contact Information: _____
- Prescriber's Signature: _____
- Date: _____

For Camp Use Only:

- Medication Received: [ ] Yes [ ] No
- Camp Staff Notified: [ ] Yes [ ] No
- Medication Stored Appropriately: [ ] Yes [ ] No

Important Notes:

- **All medications must be brought to camp in their original, pharmacy-labeled container.**
- **Any changes in medication, dosage, or administration must be communicated to the camp immediately.**

Camp First Aider Signature: _____

Medication Administration Record (MAR)

Name of Child _____ **Date of Birth** _____/_____/_____
Pharmacy Name _____ **Prescription Number** _____
Medication Order _____

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing or Administering Medication (First Aider or Staff Member Resp)
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ **Authorization form is complete**
☐ **Medication is appropriately labeled**
☐ **Medication is in original container**
☐ **Date on label is current**
☐ **The Individual Care Plan Form is complete**

Person Accepting Medication (print name) _____ **Date** _____/_____/_____