



SOUTHWEST LOCAL SCHOOL DISTRICT



2019 Summer-Camp Registration Form

Student Name: _____ Current Grade: 3 4 5

Names of Teammates (optional – everyone will be placed on a team even if this is blank):

1	
2	
3	

T-Shirt Size (circle one): YOUTH S M L XL ADULT S M L XL

Parent/Guardian Name(s): _____

Best Parent contact Info: _____

Newspaper/Website/Social Media Pictures and Names

Periodically, press releases to local papers and posts on the school website and social media accounts are made highlighting various activities and programs. In some instances names and/or photographs of students are used in these articles/postings. If you wish that your child’s name or photograph NOT be used, please indicate below:

The name/photograph of my child:

_____ **MAY NOT** be used in newspaper articles or internet postings

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Please complete both sides and return to the Harrison High School office with \$75 check made payable to Harrison Robotics no later than July 12th.

SOUTHWEST LOCAL SCHOOL DISTRICT – EMERGENCY MEDICAL AUTHORIZATION

Student's Name	Date of Birth	School Student Attends
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Student's Street Address	City	Telephone
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PURPOSE – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian

Mother's Name	Mother's Daytime Phone Number
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Father's Name	Father's Daytime Phone Number
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Name of Relative or Childcare Provider

Name	Relationship	Daytime Phone Number
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Street Address	City	Zip Code
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PART I TO GRANT CONSENT (PART I OR II MUST BE COMPLETED)

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor/Specialist Name	Phone Number
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Dentist Name	Phone Number
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Local Hospital	Emergency Room Phone Number
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In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

Date	Signature of Parent or Guardian
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PART II IS A REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART I)

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Date	Signature of Parent or Guardian
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