Looking to develop better volleyball skills?
If so, register for

# Milford High School
# Youth Volleyball Camp

- July 24th - 27th
- Grades 4 - 6  3:00 - 5:00 pm
- Grades 7-8  6:00 - 8:00 pm

**Cost: $75**

Send this form along with payment and attached emergency medical form to:

Milford High School
1 Eagles Way, Milford, Ohio 45150
Attn: Girls Volleyball

Please make checks out to "Setters Club"

Checks and late registrations accepted at the door.

Name_____

Grade (Fall of 2 016) _____

Address _____

City _____ State_____ Zip_____

Phone_____

Email address ( please print ) _____

Shirt Size: (Adult) S M L XL (Youth) S M L

Questions: Contact Head Coach Melissa Downs at miller_m@milfordschools.org

Questions about Junior High Program: Contact Erin Veatch at erin.veatch3@gmail.com

# MILFORD EXEMPTED VILLAGE SCHOOL DISTRICT

## EMERGENCY MEDICAL AUTHORIZATION FORM (2016-2017)

(Ohio Revised Code 3313-712)

**STUDENT'S NAME** _____ **STUDENT ID#:** _____ **GRADE:** _____

**STREET ADDRESS** _____ **DATE OF BIRTH:** _____

**CITY, STATE, ZIP** _____ **PARENT EMAIL:** _____

**PURPOSE:** To enable parents and guardians to authorize the provisions of emergency treatment or transportation for children who become ill or injured while under school authority, or during an emergency situation, when parents cannot be reached. **IF ANY CHANGES OCCUR, NOTIFY THE SCHOOL IMMEDIATELY.** ***(Please PRINT or TYPE, and SIGN the FORM IN THE APPROPRIATE AREAS.)***

### PARENT/LEGAL GUARDIAN:

**Student lives with: (please check)** and enter information below:

❒**Father & Mother** ❒ **Mother only** ❒ **Father only** ❒ **Shared Parenting** ❒ **Foster Parent** ❒ **Other** _____

| NAME | RELATIONSHIP | CELL PHONE | HOME PHONE | WORK PHONE |
|---|---|---|---|---|
| | | | | |
| | | | | |

**List three (3) names of people to be contacted in the EVENT OF AN EMERGENCY:**

**I understand that my child may be released to anyone on the list if ill, injured, or if an emergency occurs, and he/she must leave school.**

| NAME | RELATIONSHIP | CELL PHONE | HOME PHONE | WORK PHONE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Please provide detailed information regarding any medical problems, allergies, special needs:** _____

_____

**Medication your child takes daily:** _____

For educational purposes, special medical problems, physical impairments or other facts concerning your child's medical history may be shared with teachers or other support staff involved in the academic setting. If you **DO NOT CONSENT** for the sharing of this information, you are required to state this in writing and submit your statement with this form to your school administrator.

### PART I OR PART II MUST BE COMPLETED- *(complete ONE SECTION ONLY)*

#### PART I: TO GRANT CONSENT

**(A)** I hereby **GIVE MY CONSENT** for the following medical care providers and local hospital to be called:

DOCTOR: _____ Phone: _____

DENTIST: _____ Phone: _____

HOSPITAL: _____ Phone: _____

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.

**(B)** I authorize Milford Exempted Village School District to release any information which I have provided this school district concerning any medical history, including information regarding allergies, medications, physical condition, etc. of the student named above to any employee of the school district and/or volunteer providing medical service to the school district who has responsibility for such student while the student is at school, participating in a school sponsored function, or is being transported by the school.

**SIGNATURE OF PARENT/LEGAL GUARDIAN/ or STUDENT (IF 18 YEARS OR OLDER)** **DATE**

#### PART II: REFUSAL TO GRANT CONSENT

I **DO NOT GIVE MY CONSENT** for emergency medical treatment for my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

_____

_____

_____

_____

_____

_____

**SIGNATURE OF PARENT/LEGAL GUARDIAN/ or STUDENT (IF 18 YEARS OR OLDER)** **DATE**