Pirate Football Camp Registration Form

Forms may be submitted online at: **burgfootball.com**

800 Pirate Drive
Wheelersburg, OH 45694

Phone: 740-574-2527
Football Field house: 740-574-0564
E-mail: rob.woodward@wheelersburg.net

Registration Form is **double sided** or has **two pages**

Please print the following information on the lines provided and email or mail to the listed address

Child's Name_____

Grade 2018-2019 school year _____ Birth date:____/_____/_____

Parent/Guardian Name

_____

Email Address_____
(Not Required)

T-Shirt Size **(Circle One)** **Youth: S M L** **Adult: S M L XL 2XL**
(Sizes Guaranteed if ordered by May 25th)

I give my child _____ permission to attend the "Wheelersburg Pirate Football Camp" I hereby release the camp staff and /or Wheelersburg Local Schools form all claims on account of any injury which may be sustained by my son while attending the 2017 Wheelersburg Pirate Football Camp.

I approve of my son's participation in the Football Camp and certify that he is in good health able to participate in all camp activities. If medical attention is required for illness or injury while attending camp I give my permission for such care. I will see that proper sunscreen is applied prior to the start of camp.

_____ _____

Parent/Guardian Signature **Date Signed**

GRADE FOR 2018 - 2019 SCHOOL YEAR_____

WHEELERSBURG SCHOOLS EMERGENCY MEDICAL AUTHORIZATION FORM

Address_____ **Name**_____
_____ **Birthdate** _____
_____

Home Phone (_____)_____ **Parents Cell Phone**_____
Students Cell Phone _____

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.**

Mother's Name_____ **Daytime Phone (_____)**_____
Father's Name_____ **Daytime Phone (_____)**_____
Other's _____ Daytime Phone (_____)_____
Other's _____ Daytime Phone (_____)_____
Other's _____ Daytime Phone (_____)_____
Other's _____ Daytime Phone (_____)_____
Other's _____ Daytime Phone (_____)_____

(If additional space is needed, please use backside)

Name of Relative or Childcare Provider for emergency contact:
_____ Relationship_____
Address _____ Daytime Phone (_____)_____
_____Zip_____

PART I *OR* II MUST BE COMPLETED
***********(DO NOT SIGN BOTH THE CONSENT & THE REFUSAL)*********

PART I: TO GRANT CONSENT

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

Physician_____ Phone (_____)_____
Dentist_____ Phone (_____)_____
Medical Specialist_____ Phone (_____)_____
Local Hospital_____ Emergency Room 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 doctors, 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, and obtained prior to the performance of such surgery.

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

_____

_____

_____

Date_____ Signature of Parent/Guardian_____

Address_____ _____Zip _____

PART II: REFUSAL TO CONSENT

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/Guardian_____

Address_____ _____Zip _____