2019 Anderson Lady Redskins Youth Basketball Camp

Passion *Dedication*

Respect *Hard Work*

- Ball Handling & Dribbling
- Defense-Footwork
- One-on-One Moves
- Teamwork
- Dedicated Coaches
- Passing & Receiving
- Rebounding
- Cutting/Screening
- Positive Attitude/Respect
- Active Participants
- Shooting: Layups/Jump Shot
- Conditioning
- Rules of the Game
- Hard Work & Self Discipline
- Drills,Games, & PRIZES!

Recipe for Success

✓ Fundamentals of basketball with girls that have a positive attitude and a desire to learn the game of basketball.

✓ Understanding that the coaches, with great experiences, have a desire to want to teach the fundamentals of the game they love.

✓ New friends that will make a difference during the three days of camp.

Details

When: **June 3, 4 & 5 from 6:00pm-8:00pm**

Who: **Current 2nd - 7th graders**

Where: **Nagel Middle School**

Cost: **$75** Please register online at https://www.locallevelevents.com/events/details/6839

Or you can send registration form, payment (please make check payable to: Anderson Girls' Basketball) and Emergency Medical Authorization, found on Anderson Athletics website, to: Anderson High School 7560 Forest Road, Cincinnati, OH 45255 Attn: Girl's Basketball.

Applicant must have their own insurance. AHS, FHSD, or any camp staff will assume no responsibility for injuries (medical or dental) incurred while at these camps. In signing this application, parent/guardian assumes all and any medical risks.

I, the undersigned parent/guardian, do hereby delegate to Anderson Camps, FHSD, its employees and agents, the authority to seek, obtain and approve any medical care and treatment for the above-named minor, which, in their judgment is necessary for the health and well-being of said minor during attendance at the camp. Further, I agree to hold Anderson Camps, Anderson High School and Forest Hills School District, its employees and agents, harmless for any liability arising out of good-faith actions in seeking and obtaining medical care and treatment for the above-named minor. All costs incurred are the responsibility of the parent/guardian.

Camper Name:____

Grade (Fall 2018):____________________________________

Parent/Guardian Print Name:____

Parent/Guardian Sign Name:____ **Date:**____________

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

Questions: Contact Head Coach Phil Sheldon at phillipsheldon@foresthills.edu

New emergency medical forms are required each school year. Please carefully review the printed information. Make changes, corrections or additions as needed. Sign under Part I or Part II to indicate that you give or do not give consent for emergency medical treatment of your child.

EMERGENCY MEDICAL AUTHORIZATION

FOR ALL SCHOOL RELATED ACTIVITIES

Student Name: ______________________ DOB: __________ School: ____________________

Address: ____________________________ Grade: _____ Number: __________

Telephone: __________________ Unlisted: _____ Teacher: ______________

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, and to authorize a person to whom the school may release a child to, when parents or guardians cannot be reached.

RESIDENTIAL PARENT OR GUARDIAN:

Name	Home	Cell	Work	Type	Email Address

EMERGENCY CONTACT OTHER THAN PARENT TO WHOM MY CHILD MAY BE RELEASED IN THE CASE OF A MEDICAL OR OTHER EMERGENCY:

Name	Home	Cell	Work	Type	Email Address

PART I OR II MUST BE COMPLETED

PART I - TO GRANT CONSENT:

DOCTOR TO BE CALLED: ______________________ PHONE: ______________

DENTIST TO BE CALLED: ______________________ PHONE: ______________

MEDICAL SPECIALIST: ______________________ PHONE: ______________

HEALTH INSURANCE COMPANY: ______________________

POLICY NUMBER: ______________________ EMPLOYER PROVIDING: ______________

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.

Preferred local hospital:____________________

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.

Please check any boxes below indicating anything that we need to be aware of concerning your child:

- ☐ Asthma: Triggers ______________ Inhaler Y__ N__
- ☐ Food Allergies: To What ______________ EPI Pen Y__ N__
- ☐ Insect Allergies: To What ______________ EPI Pen Y__ N__
- ☐ Other Allergies: To What ______________ EPI Pen Y__ N__
- ☐ Medications: ______________________
- ☐ Other Health Conditions: ______________________
- ☐ Diabetes
- ☐ Heart Condition
- ☐ Seizures
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Eating Problems

Additional Information:

____

Date:______________ Signature of parent/guardian:______________________

Address: ______________________

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 no action or to:

Date:______________ Signature of parent/guardian:______________________

Address: ______________________