CLOVERLEAF SUMMER GIRLS' BASKETBALL TRAINING

***FOR ALL CLOVERLEAF HS (Grades 9-12), IT IS $60 PER PLAYER FOR ALL SUMMER ACTIVITIES TO PAY FOR ALL THE ENTRY FEES INTO LEAGUES AND SHOOTOUTS (This $60 does not include the July 21st Clinic). CASH, OR CHECKS ARE MADE PAYABLE TO "CLOVERLEAF ALL SPORTS BOOSTERS/GBB" AND WILL BE DUE BY 5/15/16 TO COACH CARM! (CURRENT 8th GRADERS GIVE TO COACH BAILEY AND SHE CAN SEND UP!)**

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June 1, 6, 8, 13 – Varsity Doubleheader League at Barberton – Games at 6 & 7 p.m.

June 13, 15, 20, 22, 27 – JV & Varsity Doubleheader League at Cloverleaf – 8-Noon

June 10 & 12 – Varsity at Women's Tri-County Shootout at Barberton – Times TBA

June 17 – Springfield JV/V Shootout – 4 games -- Varsity 9-Noon; JV Noon-3 p.m.

June 29 – Medina JV/V Shootout – 3-4 games – V & JV - 9 a.m. to 3 p.m.

July 21 – Jim Clayton Shooting Camp at Cloverleaf – ($50 to attend – great clinic!)

----Grades 2-6 from 9 a.m. to 1 p.m., and Grades 7-12 from 2 to 6 p.m.

NOTE: Coach Patterson will run some individual workouts too, especially when this slows down in June, and we will get those times to you later.

Need one for summer!

S-14a (Rev7/10)

CLOVERLEAF LOCAL SCHOOLS
ACTIVITIES EMERGENCY MEDICAL AUTHORIZATION - Students

NAME_____ PHONE_____ SCHOOL_____
(Last) (First) (Middle)

RESIDENCE ADDRESS_____
(Street/Road Number) (Post Office) (Zip)

MAILING ADDRESS_____
(Box Number) (Post Office) (Zip)

BIRTHDATE_____ Male☐ Female☐ GRADE_____ BUS#(AM)_____
(Month/Day/Year) BUS#(PM)_____

CITY OF BIRTH_____ HOMEROOM TEACHER_____ HR#_____

PART I OR PART II Must Be Completed

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.

PART I - TO GRANT CONSENT

In the event reasonable attempts to contact me at _____ (home phone) OR at work (phone # is below);

Mother's Name _____ Place of Work_____ Phone_____ Cell #_____

Father's Name _____ Place of Work_____ Phone_____ Cell #_____

STUDENT RESIDES WITH: ☐Mother ☐Father ☐Both ☐Grandparent Other_____

Or-If neither parent can be reached, I give permission for you to contact the following;

Name _____ Relationship_____ Phone_____ Cell #_____

Name _____ Relationship_____ Phone_____ Cell #_____

and/or I hereby give my consent for: (1) the administration of any treatment deemed necessary by:

Dr. _____ Phone_____ OR
(preferred physician)

Dr. _____ Phone_____ OR
(preferred dentist)

in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to

_____ _____
(preferred hospital) (Phone)

OR TO ANY HOSPITAL REASONABLY ACCESSIBLE.

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

Please provide facts concerning the child's medical history including allergies, medications being taken and any physical impairments of which the school should be aware (be specific) or indicate "none known".

_____

_____

_____ _____
Parent/Guardian Signature (verifying information and consent) Date

PART II - REFUSAL TO CONSENT - (DO NOT COMPLETE THIS PART IF PART I WAS COMPLETED)

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:

_____

Signature of Parent or Guardian _____ Date_____

Address_____