

# 2019

## SOUTH SOUND FOOTBALL CAMP



June 26, 27, & 28



Fife High School



\$60 / Player

Attend an **AFFORDABLE FOOTBALL CAMP** with your entire team

Detach form here and Return form to KHS Front Office by June 7<sup>th</sup>.

### REGISTRATION FORM

Camper's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Team: \_\_\_\_\_ T-Shirt Size: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

I hereby authorize the applicant to attend SOUTH SOUND FOOTBALL CAMP and waive and release SOUTH SOUND FOOTBALL CAMP, Fife High School, the Fife School District, and any of their representatives and / or assignees, from any and all liabilities, injuries, claims, suits or damages which might result from participation in this activity. I know of no medical or physical problems which may affect the camper's ability to safely participate in this camp. I authorize the directors of this camp to act for me in any medical emergency according to their best judgment. In the event of illness or injury, I hereby give my consent for medical treatment and assume full responsibility for any medical expenses.

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Enclosed is \$ \_\_\_\_\_

Check # \_\_\_\_\_

Paid online \_\_\_\_\_

A \$60 fee is due by June 7<sup>th</sup>.

Please make checks payable to Kingston High School, or you can pay by credit card online.

Return form to KHS Front Office by June 7<sup>th</sup>.

# ADVANTAGES

- Local football camp & transportation cost savings
- Logging cost savings & optional stay in the gymnasium (with coaches supervision)
- Coaching your own players 1 on 1
- Allows each player to succeed & grow on your team
- Each player receives a camp t-shirt & a barbeque lunch every day of camp
- Allows you to work with Varsity, JV, & Freshman players



# COACHING STAFF

FULL PADS ARE REQUIRED IN ORDER TO PARTICIPATE. Insurance requires all pads to be worn. Camp will be held on the Fife High School football fields which are natural grass & turf. Therefore, please bring appropriate cleats. Water will be available at the field, but players may want to have their own water bottles as well.

# TENTATIVE DAILY SCHEDULE

- 9 - 10 AM - CHECK IN (24th ONLY)
- 10:00 AM - STRETCH ON OWN
- 10:20 AM - TEAM PRACTICE
- 11:15 AM - 7 on 7 / OL & DL
- 11:45 AM - SCRIMMAGE #1, 11 on 11
- 12:15 PM - SCRIMMAGE #2, 11 on 11
- 12:45 PM - BREAK (LUNCH)
- 2:00 PM - WARM UP / TEAM TIME
- 2:20 PM - GROUP
- 2:45 PM - 7 on 7 / OL & DL
- 3:15 PM - SCRIMMAGE #1, 11 on 11
- 4:00 PM - SCRIMMAGE #2, 11 on 11
- 4:45 PM - BREAK CAMP
- 4:55 PM - COACHES MEETING



A \$60 fee is due by June 7<sup>th</sup>.

Please make checks payable to Kingston High School, or you can pay by credit card online.

# MEDICAL RELEASE & INSURANCE

All campers must provide proof of individual medical insurance and a signed emergency release (see attached form) South Sound Football Camp & the Fife School District will not be responsible for medical expenses incurred during camp due to illness or injury.

Completed form must be submitted to participate

North Kitsap School District No. 400

# Field Trip Permission Form

(Informed Consent Form\*District Curricular/Co-Curricular/Interscholastic Activities)

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

I. **GENERAL INFORMATION** (return this form to your child's school before May 24th and keep any attachments for your information.)

The KHS Football Team

is planning a trip to Fife, WA

The purpose of this trip is South Sound Football Camp

Trip destination Fife High School Phone Alec Grim 206-909-2455

Address 5616 20th St. E, Fife, WA 98424 Place of lodging N/A

We will leave from parents provide date/time 6/26 9am-5pm

We will return to transportation date/time 6/27-28 10am-5pm

Itinerary attached  List of items needed attached

Attending: Number of students 25 Number of adults 5

Type of Transportation:  District Vehicle  District Bus  Private Vehicle  \* NO DISTRICT transportation provided

Commercial Transportation (describe) \_\_\_\_\_ Other (describe) \*parents provide transportation

\* By signing this permission form parents/guardians accept responsibility for insuring that their student arrives to the designated departure area on time and is picked up at the specified pick up location on time.

## II. MEDICAL INFORMATION (Completed by Parent/Guardian)

### Medical Information:

The following special health problems should be noted and adequate precautions taken (list such items as unusually severe reaction to bee stings, other severe allergies, hemophilia, diabetes, heart disease, etc.)

The following medications, prescriptions, or special diets are needed:

### Medical Release:

In the event of an accident or illness, I understand that reasonable effort will be made to contact the parent immediately. However, if I am not available, I authorize the school district to secure emergency medical care, as needed.

Name of preferred doctor \_\_\_\_\_ Phone \_\_\_\_\_

Name of insurance carrier \_\_\_\_\_ Policy Number \_\_\_\_\_

This activity provides a learning experience for the students and allows them an opportunity to apply their classroom learning. Although I understand that the school district will make reasonable efforts to provide a safe environment, I am fully aware of the special dangers and risks inherent in participating in the activity. Being fully aware of the risks, I hereby give consent for my child to participate in the activity.

Parent name, please print \_\_\_\_\_ Home Phone \_\_\_\_\_

Home Address & City \_\_\_\_\_ Work Phone \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Emergency Phone \_\_\_\_\_

***NORTH KITSAP SCHOOL DISTRICT  
OVERNIGHT CAMP/FIELD TRIP/HEALTH FORM***

STUDENT NAME \_\_\_\_\_  
TEACHER/SCHOOL \_\_\_\_\_

HEALTH INFORMATION

1. Please fill out this form and return it to school at least one week before field trip/camp begins.
2. Inform the person you have listed as an emergency contact that you are doing so. If you are unavailable for instructions in an emergency, attempts will be made to contact the other name listed. Let that person know where to contact you if you plan to be away from home for several hours.  
Emergency contact: \_\_\_\_\_ Phone \_\_\_\_\_
3. If your child is taking any medication that he/she will need to bring on this trip, list the name, amount, and times to be given on the back of this page. All medications, whether prescription or over-the-counter, require a completed 3416-F1 form. (Physician's Order For Oral Medicine at School). Forms are available from your school's main office. Attach the completed form to this sheet. If possible, please send only the # of doses needed for camp in the original container with the name and dose listed on it. A designated person will be responsible for giving the medicine to your child while on this trip.
4. List any concerns you have about your child's participation in trip activities. Feel free to discuss them with school personnel.
5. If your child has any allergies, list them on the back of this page. We will be glad to help you work out any special problems so that your child will be able to participate in this activity. Send a list of known allergies and a copy of specific doctor's instructions.
5. In the event of an emergency, every attempt possible will be made to contact you to discuss your child's care. If hospitalization is necessary, we will do so. Please sign the consent form so that we will be authorized to obtain emergency care if it is indicated.
5. Does your child have any problems or conditions that would exclude him/her from participating in any activities?

~ NO ~ YES (If yes, Please list restrictions.)

5. Does your child have any allergies to: (If yes, list and explain reaction.)

1. Insect bites \_\_\_\_\_

2. Medicines \_\_\_\_\_

3. Foods \_\_\_\_\_

4. Others \_\_\_\_\_

5. Is your child taking **any** medication that will need to be given while on this trip? If so, list names of drugs, amounts and times to be given. Attach completed 3416-F1 – Physicians Order For Oral Medicine at School – to this sheet.

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5. Is there anything else that you would like us to know about your child which will help us plan for this trip?

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If my child should become seriously ill or injured while on this trip, I authorize school officials to take him/her to the nearest hospital for emergency care, if that is indicated.

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Signature and Relationship to Student

Health Notes:

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**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL**  
**For 2018-2019 School Year**

**\*\* THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP) \*\***

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Name of Medication: *(one per form)* \_\_\_\_\_

Dosage & Mode of Administration: \_\_\_\_\_

If given for allergic reason, describe indicators: \_\_\_\_\_

Time to be given: \_\_\_\_\_

Inclusive dates during which medication is to be given: \_\_\_\_\_

Possible side effects of medication: \_\_\_\_\_

Action or first aid measures required if side effects occur: \_\_\_\_\_

\_\_\_\_\_

Licensed Health Professional: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Please Print)

Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\* THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN \*\***

I request/authorize the school to administer medication to the above identified student in accordance with the LHP's instructions for a period from \_\_\_\_\_ to \_\_\_\_\_ *(not to exceed current school year)*. I understand that every effort will be made by school staff to administer the medication in a timely manner, but it is possible for a dose to be delayed or missed. I will deliver the prescribed medication to the school in the original pharmacy container with the label intact. (Student may not hand carry medication to school unless it is an Epi-Pen or Inhaler and there is an *Authorization for Self-Administration* form on file)

I agree to hold North Kitsap School District harmless for any liabilities it may incur in connection with this requested medication at school when medication is administered in accord with LHP's written direction.

School Student Attending: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_  
(Please Print)

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_