

**SAYF&C Cheerleaders are automatically registered  
for the Sycamore HS Athletic Departments  
Lil' Aves Cheer Camp  
on August 1<sup>st</sup>-4<sup>th</sup> from 6-8pm in the HS gym**

**If your daughter will be able to attend the camp:**

Please read the waiver/permission form at the bottom of this page and sign at the bottom.

Also, complete the Emergency Medical Authorization Form that is required by the Athletic Department (page 2 of this document)

Scan and email both pages to me at: [KangarooHoldings@yahoo.com](mailto:KangarooHoldings@yahoo.com)

or

Print and mail them to me at:

Cathy Chien

Cheer Director, SAYF&C

9829 Villageview Ct.

Cincinnati, OH 45241

**If your daughter will not be able to attend the camp:**

Please email me to let me know.

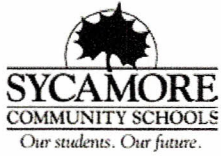
**Waiver:**

My child has permission to attend the Sycamore Community Schools Summer Camp Program. I know of no physical impairment that will affect or be affected by the camp. I acknowledge that the camp my child will participate in is a sport that will involve contact and he/she may risk injury. I specifically waive and release the Sycamore Community Schools Summer Camp Program, its employees, and staff from liability for any claims for injuries which my child may sustain at the camp.

I also authorize the coaches of Sycamore Community Schools Summer Camp Program to act for me according to their best judgment in an emergency requiring medical attention.

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Parent or Guardian Date



## EMERGENCY MEDICAL AUTHORIZATION FORM

*The purpose of this form is to enable parents and guardians to authorize emergency treatment for children who become ill or injured while under the school's authority, when parents or guardians cannot be reached. Please be sure to complete each blank. This form is also available electronically on the "District Forms" page of the district website, [www.sycamoreschools.org](http://www.sycamoreschools.org), for those who wish to type on the form. However, parents must continue to print out a hard copy of the form, sign it, and return it to the student's school at the beginning of the school year. **Email forms cannot be accepted.***

School Student is Currently Attending \_\_\_\_\_ A.M. Bus Number \_\_\_\_\_ P.M. Bus Number \_\_\_\_\_

Student Name \_\_\_\_\_ Sex (M/F) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Student ID# (if applicable) \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom \_\_\_\_\_

Student Home Address \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Ph. # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Mother's Address \_\_\_\_\_ Mother's Email \_\_\_\_\_

Mother's Home Ph. # \_\_\_\_\_ Mother's Wk. Ph.# \_\_\_\_\_ Mother's Cell Ph/Pager # \_\_\_\_\_

Father's Name \_\_\_\_\_ Father's Address \_\_\_\_\_ Father's Email \_\_\_\_\_

Father's Home Ph. # \_\_\_\_\_ Father's Wk. Ph.# \_\_\_\_\_ Father's Cell Ph/Pager # \_\_\_\_\_

Step Parent's Name \_\_\_\_\_ Step Parent's Address \_\_\_\_\_ Step Parent's Email \_\_\_\_\_

Step Parent's Home Ph. # \_\_\_\_\_ Step Parent's Wk. Ph.# \_\_\_\_\_ Step Parent's Cell Ph/Pager # \_\_\_\_\_

Who has legal custody of the student? (name and relationship) \_\_\_\_\_

Please list the child care provider, if applicable \_\_\_\_\_ Child Care Provide Phone # \_\_\_\_\_

**NAMES OF RELATIVE/CARE PROVIDER/ALTERNATE CONTACT (WHO TO CONTACT IN THE ABSENCE OF PARENT/GUARDIAN)**

Name \_\_\_\_\_ Address \_\_\_\_\_ Daytime Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Daytime Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

**\*\*\*\*\* PART I OR PART II BELOW MUST BE COMPLETED AND SIGNED \*\*\*\*\***

**PART I - TO GRANT CONSENT.** I hereby give consent for the following medical care providers/local hospital to be called.

Doctor's Name	Phone #	Address
Dentist's Name	Phone #	Address
Medical Specialist (optional)	Phone #	Address
Local Hospital	ER Phone #	Address

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 preferred hospital or 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.

**Facts concerning the child's medical history including medical conditions (ex. Diabetes, asthma, significant allergies, ADHD, autism, Down Syndrome, hearing/vision impairments, etc.) and medications being taken to which a physician should be alerted:**

\_\_\_\_\_

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

*NOTE: The above information will be shared with appropriate staff as necessary. This includes, but is not limited to, administrators, teachers, support staff, bus drivers, food service staff, custodians, coaches, and substitute employees. Please, notify the school nurse of any concerns.*

**\*\*\*\*\* DO NOT COMPLETE PART II IF YOU COMPLETED PART I \*\*\*\*\***

**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 school/district authorities to take the following action:

\_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_ (REV. 7/10)