PARKWAY NORTH HIGH SCHOOL

Viking Boys Basketball Camp 2020

Camp dates:
June 1-4 M-Th Time 1:00 pm - 3:00 pm

At North High School

Entering Grades 4-8 $50
Players will learn the Viking way of basketball. This camp will teach the fundamental skills of basketball through drills, competitions and fun games. Come dressed in gym shorts, t-shirts and tennis shoes. Cost of camp includes a t-shirt. Instruction will be led by the North High Viking coaching staff and current players. For more information, contact Coach Russell Vincent at rvincent@parkwayschools.net

Make checks payable to **Parkway North Boys Basketball**

Summer Sports Camp Registration Form

Please mail this Registration Form, the Emergency Form, and **only one check per sport** to:

Parkway North High School
Athletic Office - Summer Sports Camps
12860 Fee Fee Rd.
St. Louis, MO 63146

Camp: _____Time of camp-if applicable: _____

Name of Student: _____ Age: _____ Grade in Fall 2020_____

Address: _____

Phone: _____

Emergency Contact: _____

Emergency Contact phone: Work:_____ Cell:_____

Please read the following:
I, the undersigned parent/guardian, agree and understand that all camps are taken at the participant's own risk, without liability to the Parkway School District, its officials, or instructors. Although accidents rarely occur, those participating should have their own insurance or be aware that expenses for any medical treatment or care must be borne by the individual participant.

Read and understood (Parent Signature) _____ Date: _____

ATHLETIC EMERGENCY CARD

TO PARENTS: Please fill out both sides of Student Emergency Card, sign and date.

Print Student Name _____ Date of Birth _____Grade_____

Address _____ City _____State _____ Zip_____

Phone Numbers: Home _____

Father _____ Work # _____ Cell #_____

Mother _____ Work # _____ Cell # _____

Emergency Contact Person _____ Home # _____ Cell #_____

Physician _____ Phone _____

Dentist _____ Phone_____

LIST KNOWN DRUG ALLERGIES_____

Will your child bring medication (prescription or over-the-counter)? YES _____ NO _____

If yes, please specify:

Name of Medication	Physician	Dosage/Frequency	Special Instructions

Please provide other health information which would help us meet the needs of your child. Include such conditions as: serious allergies, asthma, diabetes, ear and eye problems, heart conditions, seizure disorders, orthopedic conditions; any specialized health care needs; dietary restrictions.

_____

_____

_____

Date of last DT (Diphtheria/Tetanus Immunization): _____

All medication brought by your child will be self-carried, self-administered, and must meet the following criteria:

Prescription Medication:

All medication brought must have a current prescription label properly affixed to the medication in question. The label must contain the name of the child, name of drug, dosage, frequency of administration, diagnosis, and physician's name.

Over-the-counter Medication:

This medication must be in the original bottle. Place child's name on bottle.

IN CASE OF EMERGENCY, I request my child be taken to _____ hospital. If the school or hospital is unable to contact me, I hereby authorize the school and/or physician to treat my child as they deem necessary.

Physical Exam Date _____

Insurance Information: Company Name _____ Policy Number _____

_____ _____

Signature of Parent or Guardian Date

OFFICE USE: EMERGENCY CARD TO BE RETAINED BY SPONSOR/COACH AND TAKEN ON TRIP

Parkway School District

Form # 226 (Rev. 12/06)