

Marshall 2018

Incoming 9th Grade Volleyball Camp

Camps are conducted by Head Coach Danielle Nichols (danielle.nichols@nisd.net, (210)397-7167) and my coaching staff. You can count on having a fun, energetic, hard and fundamental workout.

Camp Date: July 30—July 31 (Monday—Tuesday)

Camp Times: 4:00 PM — 7:00 PM

Location: Marshall High School Competition Gym

Cost: \$15 *****No Refunds****

Due by Tuesday May 22nd, **you can pay at the door but no t-shirt will be guarantee**

Parent waiver form. You must fill out and sign the CONSENT TO STUDENT ACTIVITY PARTICIPATION & MEDICAL TREATMENT FORM. These two pages must be returned with your camper on the day of camp.

YOU MUST BE IN THE MARSHALL ATTENDANCE ZONE TO ATTEND MARSHALL CAMP

Please Mail Registration Form and payment to: 8000 Lobo Lane San Antonio, TX 78240

Attention: Danielle Nichols **Make checks payable to John Marshall High School**

Name: _____ Incoming Grade: _____ Middle School: _____

Address: _____ Zip: _____

Parent Number _____ Parent Email Address: _____

Parent Name: _____

Parent Signature: _____ Date: _____

Emergency Contact Number: _____

Special Medical Needs: _____

Circle T-Shirt size : YL S M L XL

Method of Payment:

Cash Check # _____

Make checks payable to John Marshall High School

Northside ISD

**CONSENT TO STUDENT ACTIVITY PARTICIPATION
& MEDICAL TREATMENT FORM**

Northside ISD is proud to offer the opportunity for our students to participate in the _____
(*describe event*). We ask that you read and sign this form as a condition of participation in the activity.

PLEASE NOTE THAT THIS DOCUMENT HAS IMPORTANT LEGAL CONSEQUENCES, INCLUDING A RELEASE OF LIABILITY FOR INJURIES OR DAMAGES SUFFERED AND AN AGREEMENT TO INDEMNIFY NORTHSIDE ISD FOR CLAIMS ASSERTED AS A RESULT OF SUCH INJURIES OR DAMAGES. IF YOU HAVE QUESTIONS REGARDING THE EFFECT OF THIS RELEASE, YOU ARE ENCOURAGED TO CONSULT LEGAL COUNSEL.

I, as (*parent or guardian*) of _____, desire that my (*child or ward*) participate in _____ (*describe the event*) and grant permission for my (*child or ward*) to participate in and attend. I realize that any event involves some possible inherent risk of injury to my child/ward.

I VOLUNTARILY WAIVE ANY AND ALL ACTIONS, CLAIMS, AND DEMANDS FOR, UPON, OR BY REASON OF ANY DAMAGE OR LOSS TO PERSON OR PROPERTY THAT I OR MY CHILD/WARD MAY DIRECTLY OR INDIRECTLY SUFFER DURING THE COURSE OF OR AS A RESULT OF PARTICIPATING IN THIS EVENT, INCLUDING CLAIMS OR DEMANDS OF ANY ORIGIN, INCLUDING THOSE ARISING AS A RESULT OF THE NEGLIGENCE OF THE NORTHSIDE INDEPENDENT SCHOOL DISTRICT, ITS TRUSTEES, EMPLOYEES, REPRESENTATIVES, AND AGENTS, IN BOTH THEIR OFFICIAL AND INDIVIDUAL CAPACITIES, FROM ANY AND ALL SUCH CLAIMS, WHETHER BY ACT OR OMISSION.

I further understand that, as a parent or legal guardian, I may be held responsible if my child or ward causes bodily injury to other individuals, causes property damage to personal or real property, or engages in conduct that gives those individuals harmed the right to restitution. In the event third parties bring claims resulting from my child's/ward's actions, I HEREBY AGREE TO INDEMNIFY AND HOLD HARMLESS THE NORTHSIDE INDEPENDENT SCHOOL DISTRICT, ITS TRUSTEES, EMPLOYEES, AND AGENTS, IN BOTH THEIR OFFICIAL AND INDIVIDUAL CAPACITIES, FROM ANY AND ALL SUCH CLAIMS.

Please check one or both, as appropriate, and then sign:

Consent to Medical Treatment

I hereby authorize the sponsors for this event, on behalf of Northside Independent School District, in the case of a medical emergency during the event, to consent to medical treatment of my child or ward, _____ (*name of child or ward*).

Consent to Administration of Medications

I hereby request the sponsors for this event to administer to my child the medications listed on this form. I recognize that the school does not thereby undertake any ongoing duty to administer drugs or medicine, or to supervise or participate in any self-medication, all of which remain my responsibility. I understand that the school is not legally obligated to store or administer medication for students and will not do so, either on a temporary or ongoing basis, except by special agreement. Before any medication is given by the school, I will provide those medications in their original pharmacy containers, with the child's name and doctor's instructions on the label, and I will provide a written, signed authorization from a physician, including complete instructions.

My child/ward is allergic to:

My child/ward has the following special medical conditions:

My child/ward takes the following prescription medications:

I understand that this release will bind me, my assigns, my personal representatives, and my heirs. I have read and understood this *Consent to Student Activity Participation and Medical Treatment* and have signed it voluntarily with full knowledge of its significance, in valuable consideration of my child's/ward's participation in the event.

Parent or Guardian Signature

Date

Parent or Guardian Signature

Date

Student Signature (*required if Student is 18 or older*) Date

The following individuals may be contacted at the numbers below if I am not available in case of an emergency:

Name (*please print*)

Phone number

Name (*please print*)

Phone number