2019

DEFIANCE COUNTY SUMMER MANUFACTURING CAMP

West Side at Fairview Middle School

WHO: Students entering grades 6 ,7,8 in the fall

When: July 15th-18th
8:30 am - 3:00 pm

Where: Fairview Middle School

Cost: $50. Includes snacks, lunches, tours, and t-shirt. Space is limited and will be filled on a first come basis.

Name of Camper _____

Age _____ Grade entering in fall _____

Parent/Guardian Name _____

Address, City, State, Zip _____

_____

Home Phone, Cell Phone _____

Emergency Contact (different from above number)

_____

Email Address _____

School Attending _____

T-shirt Size

(youth sizes) ___ small ___ medium ___large ___ X-large

(adult sizes) ___ small ___ medium ___ large ___ X-large

Payment Method:
Please make checks payable to Defiance County Economic Development
Please complete the medical and photo release form on the back.

Ways to Register: Fill out the registration form and mail to: Defiance County Economic Development, 1300 E. 2nd Street Suite 201, Defiance, OH 43512
Please contact Carla Hinkle or Kortney Williams at 419-784-4471 to learn how to apply for a needs-based scholarship opportunity.

Emergency Medical Authorization Form

Camper's Name_____ Telephone Number **(____)**_____
Street_____ Cellphone Number **(____)**_____
City_____ State_____ Zip Code_____

Residential Parent or Guardian:
Mother's Name_____ Day Time Phone (_____)_____
Father's Name_____ Day Time Phone (_____)_____
Other's Name_____ Relationship_____ Day Time Phone (_____)_____

Name of Relative or emergency contact:
_____ Relationship_____ Phone Number (_____)_____
Street_____ City_____ State_____ Zip Code_____

Part I: To Grant Consent:
I hereby give consent for the following medical care providers and local hospitals to be called:
Physician_____ Telephone Number (____)_____
Dentist_____ Telephone Number (____)_____
Local Hospital_____ Telephone Number (____)_____
In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the (1) administration of any treatment deemed necessary by above-named doctors, 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 any hospital reasonably accessible. This authorization does NOT cover major surgery unless the medical options of two 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 allergies, medications being taken and any physical impairment to which a physician should be alerted:

_____
_____
_____

Date_____ Signature of Parent or Guardian_____

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 the authorities to take the following action:

_____
_____
_____

Date_____ Signature of Parent or Guardian_____

Food or other allergies? If your child has a food or other allergy, please let us know **IMMEDIATELY**! List any allergies and special instructions for treatment:

_____

Any special notes regarding your child to be aware of

_____

Promotional Release - I give Defiance County Economic Development permission to use my child's photo in various advertising and promotional brochures.

Parent/Guardian Signature _____