2009 RUHS SUMMER RUNNING CAMP

Behavior Contract & Medical Treatment Consent Form

VERY IMPORTANT

PARENTS. Please read and emphasize the following with your athlete.
A parent signature is required to attend camp!

BEHAVIOR

We have approximately 40 athletes going to camp. Athletes are expected to behave properly and obey all clearly stated camp rules. As a parent, you may be responsible to come pick up your athlete at PCCCI if they become a behavior problem or willfully disobey clearly stated camp rules **especially during sleep hours between 10 pm and 7 am.**

Be assured we do not wish to ask any parent to pick up their son or daughter at Big Bear Lake. Therefore, the rules and behavior will be clearly stated, reviewed with the athletes by both camp management and their individual coaches, and finally the athlete will be required to sign a list of rules and behavior standards to acknowledging these rules and their consequences.

TO CAMP

Redondo Union High School; 1:00 p.m. on Sunday, August 2.

FROM CAMP

Depart around 10:00 am, should arrive at RUHS by 2:00 PM on Friday, August 7.

Your coach's supervision ends when your son or daughter departs the bus on the return to Redondo Union High School. Please be there to meet them and/or arrange for their transportation and any other needs. Parents, we greatly appreciate your help, especially with the behavior. I have read and reviewed this information with my son or daughter.

PARENTS SIGNATURE_____ **DAY TELEPHONE**_____

NIGHT TELEPHONE_____

AUTHORIZATION TO CONSENT TREATMENT OF MINOR

(I), (WE), the undersigned, parent(s)/guardian of _____ a minor, do herby authorize Camp Coaches and Camp Counselors as agent(s) for the undersigned to consent to any x-ray exam, anesthetic, medical or surgical diagnosis to treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provision of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physicians in the exercise of his best judgment may deem advisable.

This shall remain effective through August 7, 2009 unless sooner revoked in writing and delivered to and acknowledged by said agent(s).

Date:_____

Witness_____ Father_____

Witness_____ Mother_____

Witness_____ Legal Guardian_____

Please indicate your medical insurance carrier below:

Company _____ Policy/Group # _____

Insurance Company Claims Department or Customer Service Phone # _____