

Memorial High School

Summer Training Program for Incoming Freshmen through seniors

This summer we will again be offering strength and athletics program conducted by coaches from Memorial High School. The program will be offered to all students at Memorial who are **incoming freshmen through seniors**. Only students that are zoned to Memorial will be allowed to participate in this program. The focus of the program will be explosive strength, agility, speed development, and sprint conditioning. These workouts cannot and will not be sports specific and each participant may only attend one two-hour session a day. No make up sessions will be provided. Attendance at every session is not mandatory as to allow participants the flexibility to attend family vacations and the like. We encourage all of our Mustang athletes to participate in this program, as it will be an opportunity to work and bond with your fellow Mustang athletes as well as work with an experienced staff at a reasonable price.

This year we are making some slight changes to the program. First there will be no afternoon session. Secondly we will start our sessions at 7:30 am and 8:30am. Lastly we will designate the sessions for returnees and newcomers. A "returnee" is a student athlete that has already participated at Memorial or is entering as an upperclassmen. A "newcomer" is a student athlete that will be entering Memorial as a 9th grader or is a novice in the weight room. Unlike previous years we will also be taking a week long break from July 2 thru July 5 for the Fourth of July Holiday.

Each participant in this program must have a physical on file with our athletic department. It will also be necessary for each participant to turn in a **signed registration form** and complete a **"Consent to Treat Form"**. If you participated in athletics this year at Memorial or one of the feeder Spring Branch ISD Middle schools, the physical you turned in will be sufficient. If you are a student who did not participate in athletics this past year or are entering this year from a school outside of our school district, we will need a copy of your athletic physical.

We will meet in the Memorial High School field house weight room daily throughout the length of the camp.

Dates.

Monday June 11 -Thursday July 26 (no workouts during the week of July 2 thru July 6)

Monday through Thursday each week

Times

Session I -7:30 am-9:30 am returnee-designated for athletes who have already participated in a program at Memorial

Session II- 8:30am-10:30am newcomers-designated for athletes new to Memorial.

The workouts will take place at the Memorial High School field house weight room located across Echo Lane (east) from the main campus.

Cost

\$100.00 for each participant.

Adjustments will be made for those students who are on free and reduced lunch.

Makes Checks Payable to S.B.I.S.D. You may Mail your payment to Memorial High School Attention Coach Gary Koch 935 Echo Lane Houston, TX. 77024, or you may bring the payment and forms with you on the first day of camp.

Questions about our program should be directed to Coach Koch @ 713-251-2745, or e-mail gary.koch@springbranchisd.com.

Memorial High School Summer Training Program
Registration Form and Emergency Information

Registration:

Name _____ Age _____

Grade (Fall '18) _____ School Attended Last Year _____

Physical on file _____ (if not @ S.B.I.S.D school you must give us a copy of last years physical)

Address _____

City _____ State _____ Zip _____

Home Phone _____

Parent/Guardian Name _____ Daytime Phone _____

MAKE CHECKS PAYABLE TO S.B.I.S.D.

I, the undersigned, being the individual, parent, or legally authorized guardian of _____, agree to hold Spring Branch Independent School District, its Board of Trustees, administration, and/or faculty, harmless from liability for any injuries which my child may receive while participating in any recreational activities or utilizing the Spring Branch Independent School District facilities. I herewith authorize the director, supervisor, and/or district employee to secure medical services for any family member if necessary, and I agree to pay either directly or through my own personal health and accident insurance policy, all medical or hospital costs.

Signature of parent or legal guardian

Date

Street address of parent or legal guardian

City/State

Zip

Phone

**A CURRENT PHYSICAL MUST BE ON FILE WITH SPRING BRANCH ISD
ATHLETIC OFFICE OR MEMORIAL HIGH SCHOOL BEFORE ANY
ATHLETE MAY PARTICIPATE.**

2017-2018

Authorization to Consent to Treatment of a Minor

CFI

Student's Name _____ Birthdate: _____ / _____ / _____ Student ID#: _____
 Print (Last),(First)(Middle (Mo) (Day) (Yr)
 Sex: (circle one) M F Grade Level: _____ Sport _____
 Home address: _____ Zip: _____
 Home phone w/area code: _____
 Father's name: _____ Business/Cell phone: _____
 Mother's name _____ Business/Cell phone: _____
 List another person to be notified in case of emergency if parents are not available:
 1. _____ Relationship: _____
 Home phone: _____ Business/Cell phone: _____
 Special Medical Conditions to be noted (i.e. Allergies, Medications, Disorders) _____

(I)(We), the undersigned, parent(s) do hereby authorize any official of Spring Branch Independent School District to act as designee for the above named minor to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is prescribed by, and is to be rendered under the special supervision of, any licensed physician/or surgeon, whether such diagnosis or treatment is rendered at the office of said physician/or surgeon or at a hospital or elsewhere.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being rendered and is given to provide authority and power on the part of our aforesaid designee to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician/surgeon may, for reasons he/she deems appropriate, prescribe.

(I)(We), hereby authorize any hospital which has provided treatment to the above named minor to surrender physical custody of such minor to (my)(our) named designee(s) upon completion of treatment. This authorization is given for designee(s) for those times that (I)(We) cannot be reached by telephone at home or work at the numbers listed below.

This authorization is not to be construed as releasing any physician or surgeon from any requirement that he or she adhere to the lawful standard of care in attending to the named minor and is not to be construed as creating any financial responsibility on the part of the Spring Branch Independent School District or the named officials thereof for any health care provided the named minor. PARENTS ARE RESPONSIBLE FOR PAYMENT.

This authorization shall become effective as of _____ 20____ and remain effective until _____ 20____

Authorization for the Release of Medical Information

The Family Education Right to Privacy Act (FERPA) is a federal law that governs the release of a student's educational records, including personal identifiable information (name, address, social security number, etc.) from those records. Medical information is considered a part of a student athlete's educational record.

This authorization permits physicians to disclose information concerning my medical status, medical condition, injuries, prognosis, diagnosis, and related personal identifiable health information to the authorized parties as follows: the licensed athletic trainers, team physicians, and athletic staff (including coaches) of Spring Branch ISD. This information includes injuries or illnesses relevant to past, present, or future participation in athletics.

The purpose of a disclosure is to inform authorized parties of the nature, diagnosis, prognosis or treatment concerning my medical condition and any injuries or illnesses. I understand once the information is disclosed it is subject to re-disclosure and is no longer protected.

I understand that Spring Branch ISD will not receive compensation for its disclosure of the information. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information disclosed under this authorization.

I understand that I may revoke this authorization at any time by providing written notification to the head athletic trainer at the respective high school. Should I choose to revoke this authorization, I understand that I must present the SBISD licensed athletic trainer with documentation provided by the doctor mandating his/her directions regarding care or discharge. I understand revocation will not have any effect on actions Spring Branch ISD had taken in reliance on this authorization prior to receiving the revocation. This authorization expires at the conclusion of each school year.

Student ID# _____

Printed Name of Student: _____

Student Signature: _____

Printed Name of Parent: _____

Parent Signature: _____ Date: _____