Memorial High School
Summer Training Program

This summer we will again be offering strength and conditioning 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. This year we will have a one week break in the program during the week of July 2-5. 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.
Each participant in this program must have a physical on file with our athletic department. If you participated in athletics this year at Memorial or one of the feeder Spring Branch ISD Middle schools, your physical 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.

Dates
Monday June 11-Thursday July 27 (break July 2-July 5)
Monday through Thursday each week

Times
Session I –8:00 am-10:00 am
Session II- 4:00pm-6:00pm
The workouts will take place at the Memorial High School field house weight room.

Cost
$100.00 for each participant.
Adjustments will be made for those students who are on free and reduced lunch.

Questions about our program should de 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'12)_____ 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.

2012-2013 Authorization to Consent to Treatment of a Minor S-01

Student's Name_____Birthdate:_____/_____/_____ SS#:_____/_____/_____
Print (Last),(First)(Middle (Mo) (Day) (Yr)

Sex: (circle one) M F GradeLevel:_____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)_____

_____

(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____

Signature of Parent or Legal Guardian: _____

Insurance Information is required if Insurance Waiver is Signed.

Provide a photocopy of your insurance I.D. card.

Insurance Company Name:_____

Policy Number:_____**Group Number:**_____

Name on Policy:_____

For Office Use Only: SBISD Ins.?	**Yes**	**No**