

2018

# DEFIANCE COUNTY SUMMER MANUFACTURING CAMP

## Camp Details

**When:** July 17th - 20th

8:30 am - 3:00 pm

**Where:** Defiance Middle School

1755 Palmer Drive

Defiance, OH 43512

**Cost:** \$50. Includes snacks,

lunches, tours, and t-shirt.

Space is limited and will be

filled on a first come basis.

**Registration Deadline:** June 1st

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 \_\_\_ XX-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. We will be accepting no more than 30 students, first come first served.

## 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:**

\_\_\_\_\_  
\_\_\_\_\_

**Promotional Release** - I give Defiance County Economic Development permission to use my child's photo in various advertising and promotional brochures. YES\_\_\_ NO\_\_\_

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:

\_\_\_\_\_  
\_\_\_\_\_

**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**

\_\_\_\_\_  
\_\_\_\_\_