

2nd–8th grade SVT Camp

SVT Camp
Saturday, November 3, 2018



Spokane Valley Tech SVT camps will engage students in a variety of activities that relate to the courses taught at Spokane Valley Tech including Biomed, Engineering, Computer Science, Manufacturing and EMT. The cost of camp is **\$30.00 per student**. All funds raised will support the Spokane Valley Tech ASB. Enrollment forms may be mailed or dropped off (7:30 AM-3:30 PM) at SVT. Please plan to pay with cash or a check. Checks should be made to SVT ASB.

Choose one of the following sessions:

9:00 AM- 11:00 AM

12:00 PM- 2:00 PM

Student Last Name:		
Student First Name:		Gender: circle one Male Female
Street Address:		
City:	State:	Zip:
School:		Grade:
Parent Name:		Phone:
Parent Name:		Phone:
Parent Email: Please print clearly. This will be the primary means of communication.		
Emergency Contact:		Phone:
Participants may be recognized through school and district newsletters, the news media (newspaper, television, radio) and on the Internet (school/district websites and school/district Facebook). Please check the box below only if you want to exclude your student's name and photo from publication. <input type="checkbox"/> I do NOT want my student included in district and news media publications.		

Please complete and return this form to SVT at 115 S. University Road, Suite B, Spokane Valley, WA 99206. Attached \$30.00. Cash or check only. Checks to SVT ASB. No refunds.



CENTRAL VALLEY
SCHOOL DISTRICT #356

SVT Camp Permission Form

I, the undersigned parent or guardian, give my permission for my student to participate in the SVT Camp:

Date: _____ Location: Spokane Valley Tech



Emergency Medical Information and Authorization:

Student's Name _____ **Home Phone** _____

Doctor's Name _____ **Phone** _____

Dentist's Name _____ **Phone** _____

Alternate Emergency Contact _____ **Phone** _____

Permission to treat if necessary: Yes No

Permission to transport to nearest medical facility if unable to reach parent/guardian/custodian:

Yes No

To: Emergency Medical Personnel:

I, the undersigned parent/guardian/custodian of _____
Student's name

a minor, authorize accompanying school personnel to consent in any emergency situation to any xray examination, laboratory test, anesthetic, medical or surgical procedure or hospital care required on the above minor while in their custody, and for which I am unable to be reached to provide consent. Such care must be recommended by and performed under the supervision of a physician licensed to practice medicine in the United States. I understand that if transportation by ambulance is necessary, I must assume the financial responsibility. My student may be released to accompanying school personnel following completion of treatment and in my absence.

Please list any allergies your student may have, any medications being taken, special health problems we should know to assist in your student's safety. (ie Heart condition, hemophilia, diabetes, asthma, other)

Allergies: _____ **Medications:** _____

Other considerations: _____

Current physician and parent permission forms for Administration of Medication at School must be obtained if medication is not routinely being given at school. I understand the district does not provide medical insurance for my student for purposes of this camp, and I am solely responsible for providing insurance and for payment of any medical treatment expenses for my student that are not covered by insurance. I have read the foregoing information, verify its accuracy, and agree to the statements made above.

Parent/Guardian Signature

Date signed