2016
Summer Session

☐ August 8th – 11th

Scott Hazelton Basketball School
Emergency Form
781-942-2564

PLEASE PRINT

Participant Information

Participant's Name:_____
Last M.I. First

Date of Birth:_____ Age:_____ Grade Next School Year:_____
Month/Day/Year

Parent/Guardian Information

Parent/Guardian #1:_____
Home Phone: _____
Work Phone:_____
Cell Phone:_____
E-mail Address:_____

Parent/Guardian #2_____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
E-Mail Address: _____

Emergency Contact

If a parent/guardian is unavailable, please list an adult familiar with your child that we may call in case of an emergency.

Name:_____ Relationship:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____

Medical Information

Medical Insurance Carrier:_____ Subscriber #: _____
Participant's Physician:_____ Telephone:_____
Participant's Dentist:_____ Telephone:_____

Does your child wear contact lenses?_____
Does your child have any medical condition that we should be aware of?_____
_____
Allergies (please describe, if any):_____
Current Medications (Please describe, if any):_____
Will any medications be taken at the clinic?_____

RELEASE STATEMENT

I, the parent/guardian of _____, give permission for my child to receive emergency medical treatment and hospitalization, if necessary. I understand that every attempt will be made to contact me, and/or the emergency contact above, before taking this action. By enrolling my child, I ensure that he is physically and mentally able to participate in all of the program activities. I hereby wave and release the Scott Hazelton Basketball School – its Directors and Staff from any liability for any injury or illness incurred while attending the clinic. I understand that there is a risk of injury to my child as a result of clinic activities, and knowingly and voluntarily assume all risk of such injury. I will be financially responsible for any medical attention needed during the clinic or resulting from any injury received at the clinic. My medical insurance shall be the insurance of coverage for any medical treatment. In absence of insurance, I agree to pay all charges.

_____ _____
SIGNED (Parent/Guardian) **DATE**