2018 APPLICATION FOR **THE HOOP GROUP** CAMPS

PO Box 633
Yarmouthport, MA 02675
(617) 899-5433

Please check the camp(s) you are applying for this year:

☐ The **ALL-CAPE HOOP** Camp (Boys & Girls ages 12 to 17)

☐ The **ALL-CAPE ROOKIE** Camp (Boys & Girls ages 8 to 11)

Name _____

Address _____

City, State Zip _____

Phone- Home( ) _____ Summer or Work( ) _____ Cell( ) _____

Age by September.1st. _____ Height _____

e-mail Address _____

Do you want mail sent to your Summer Address? _____

Emergency Contact _____
(Name & Phone)

Insurance Company & Policy No. _____

FULL PAYMENT for **ALL-CAPE HOOP** CAMP Session:$**250**
FULL PAYMENT for **ALL-CAPE ROOKIE** CAMP Session:$**175**

PLEASE MAKE CHECKS PAYABLE to All Cape Hoop Camps

Please enclose your full payment with this application and mail to the address above. ***Your cancelled check will be your receipt.*** You will be contacted prior to the start of the session. At that time, you will receive an information letter and medical information form, if the form was not previously submitted, for completion.

_____
PARENT'S or GUARDIAN'S SIGNATURE

Date_____/_____/_____

Rev 10/10

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Camper Medical Report

(Report must be completed and submitted prior to the start of the camp)

_____DOB____/____/_____was examined on___/___/_____ and was found to be in good health and able to participate in school/daycare/camp or athletic activities.

Restrictions: _____

_____

_____

The parent/guardian, by his/her signature, deny any significant health problems have occurred since the above date.

_____

Parent/Guardian Signature ***Date*** ***Physician/Provider Signature*** ***Date***

This form, if signed by both parent and physician is valid for up to one year from the date of the exam and can be copied for further use during this period.

Immunization Record:

DPT/Dtap OPV/IPV Scoliosis Check _____

1.	1.	Allergies	
2.	2.	HCT	Lead(Pb)
3.	3.	UA	TB
4.	4.	Ht.	Wt.
5.	5.	BP	Pulse
TD			
MMR	Hep B	Hib	Varivax
1.	1.	1.	1.
2.	2.	2.	2.
		3.	
		4.	

Prevnar: 1. 2. 3. 4.

Chicken Pox

Pertinent Medical Information:

IMPORTANT: Has this camper been exposed to any communicable disease within the last six months?

Yes O No O (If Yes,, state type and date of exposure_____

HEALTH HISTORY: (Check, giving approximate dates)

Ear Infections	**Allergies:**	**Diseases:**
Rheumatic Fever	Hay Fever	Chicken Pox
Convulsion	Ivy Poisoning, etc.	Measles
Diabetes	Insect Stings	German Measles
Behavior	Penicillin	Mumps
Asthma	Other Drugs	Other Contagious Diseases

Other Past Illnesses _____

Operations or Serious Injuries (Dates) _____

Hospitalization (Dates) _____

Chronic or Recurring Illness _____

Any specific activities to be encouraged? _____

Conditions that require activity to be restricted? _____

Permission for all program activities unless otherwise noted by Dr: _____

Appliance worn (glasses, contacts, etc.) _____

Medication taken _____

Suggestion from Parent/Guardian) _____

Consent for Emergency Medical Treatment

**** THIS FORM MUST BE SIGNED FOR FULL PARTICIPATION ****

By enrolling player, I ensure that such individual is physically and mentally able to participate in all of the camp's activities. I understand HOOP GROUP, INC and its related camps, its shareholders, directors, officers, employees, representatives, independent contractors, the property where the session is held and any or all of its officials cannot be held responsible in whole or in part for any accidents resulting in medical or dental expenses incurred from participation in the program and I release each of them from and against any other claims, costs, liabilities and injuries incurred while at the camp. I agree to assume full and complete responsibility for any and all medical bills resulting from player's participation. In the event of an emergency, I authorize the camp to exercise its' judgment in the treatment of said player by a medical authority.

I do hereby give authority to the Hoop Group, Inc. and its staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

_____

Signature of Parent or Guardian *Relationship*

Date____/____/_____ *Telephone(_____)_____-_____*

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