2017 REGISTRATION

THE HOOP GROUP

PO BOX 633
YARMOUTHPORT,MA 02675
(617) 899-5433

The **HOOP FEVER** Camp

April 17 to April 21, 2017

Name ____

Address ____

City, State Zip

____ Phone- Home(__________

______________) Work(____________)________Cell(________________________)________

Age by May.1st. ______Height _______

e-mail Address ____

Emergency Contact ____
(Name & Phone)

Insurance Company & Policy No. ____

FULL PAYMENT for **HOOP FEVER** CAMP $175

Refundable until April 10, 2017

PLEASE MAKE CHECKS PAYABLE to HOOP FEVER

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 01/16

PO BOX 633
YARMOUTHPORT,MA 01746
(617) 899-5433

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 No (If Yes,, state type and date of exposure______________________________

Rev 02/03

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

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(_____)______-_________*

Rev 12/05