

2009 APPLICATION FOR THE HOOP GROUP, INC. CAMPS



PO BOX 6494
HOLLISTON, MA 01746
(508) 429-7121



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

- The **Red Auerbach Basketball School** FOR BOYS
- The COED **All-Cape Hoop Camp With K.C.**
- The **All-Cape Rookie Camp for Kids**
- The **Hoop Fever Camp**
- The **Hoop Fever Rookie Camp**

Name _____

Address _____

City, State Zip _____

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

Age by Sept.1st. _____ Height _____ Name of New Camper I brought to Camp _____
(Save \$15! Red Auerbach School Only)

e-mail Address _____

Summer Address _____

(if applicable & different from above) (Accepting Mail? Yes ___ No ___ If YES, as of what date? _____)

Emergency Contact _____
(Name & Phone)

Insurance Company & Policy No. _____

Roommate Request* _____
(*Red Auerbach School only-there may be a limited number of triples)

DEPOSIT for **RED'S** CAMP \$340 OR \$680 TOTAL
Early Payment \$655 (must be received by March 1, 2009)
 FULL PAYMENT for **All-CAPE** with **K.C.** CAMP \$260
 FULL PAYMENT for **All-CAPE ROOKIE** CAMP \$185
 FULL PAYMENT for **HOOP FEVER CAMP** \$260
 FULL PAYMENT for **HOOP FEVER ROOKIE CAMP** \$185

PLEASE MAKE CHECKS PAYABLE TO THE APPROPRIATE CAMP

Please enclose your deposit or full payment with this application and mail to the address above. **Your cancelled check(s) will be your receipt.** You will be contacted about one month 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 ____/____/____



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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 No (If Yes,, state type and date of exposure _____)

HEALTH HISTORY: (Check, giving approximate dates)

	Allergies:	Diseases:
Ear Infections		
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(____)____-_____