

2010 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**

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)

T-Shirt size (please circle)    S    M    L    XL    XXL

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 \$660 (must be received by March 1, 2010)*  
**FULL PAYMENT for All-CAPE with K.C. CAMP \$260**  
**FULL PAYMENT for All-CAPE 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)

	<b>Allergies:</b>	<b>Diseases:</b>
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(\_\_\_\_)\_\_\_\_-\_\_\_\_\_