

**YMCA of Martha's Vineyard Registration Form
BASKETBALL CLINIC Summer 2020**

Participant's Name: _____ D.O.B _____ Gender _____

Parent's Name: _____ D.O.B _____ Gender _____

Mailing Address: _____ Town _____ Zip _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____ Membership Type: Member Non-member
(circle one)

Emergency Contact Name _____ Phone # _____

Basketball Clinic runs Monday through Friday 9:00 to 11:00 am for children ages 8-12 years old. Clinic taught by Coach Asil Cash. \$125 for members per session and \$150 general public per session.

Please indicate which Basketball Clinic sessions participant will attend:

_____ July Session I: July 6-10

_____ July Session II: July 27-31

_____ August Session I: August 3-7

_____ August Session II: August 24-28

Please list any allergies to bee stings, food, medications, etc: _____

Please list any medications (including inhalers) that the camper is on: _____

Please indicate if your child is under the care of a physician for any of the following conditions (circle all that apply):

Seizure Disorder

Ear infection/tubes

Diabetes

Convulsions

Insect Stings/Allergy/Sensitivity

Penicillin Allergy

Asthma

ADD/ADHD Other

Any recommendations and/or restrictions while at camp: _____

Any additional health information: _____

I give permission to use any pictures taken of my child during participation at camp for promotional purposes. I hereby give permission to the medical personnel selected by the camp to order x-rays, routine tests, and treatment for my child. In the event that I cannot be reached in an emergency, I also hereby permit the physician selected by the camp staff to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. I also give permission for routine medical care for my child by the camp. This form may be photocopied for use off camp property.

Signature: _____ **Date:** _____