



SHOT DOC NATION BASKETBALL CAMP Registration Form



Child's First Name _____ M.I. ____ Last Name _____

Male ____ Female ____ Parent's Email _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age ____ Present School _____

Mothers/Guardian Name _____

Home Number _____ Work Number _____ Cell Number _____

Fathers/Guardian Name _____

Home Number _____ Work Number _____ Cell Number _____

Emergency Contact _____

Home Number _____ Work Number _____ Cell Number _____

Student Medical Information: (This section must be fully completed prior to participation.)

Insurance Company _____ Policy Number _____

Date of last Tetanus Shot _____

Does your child have any medical problems ____ (Yes) ____ (No)

Please state your child's medical problem(s) _____

Family Doctor _____ Phone _____

I approve of my child's attendance in the **SHOT DOC NATION BASKETBALL CAMP** and certify that my child is in good health. If medical attention is required for illness or injury during the camp, I grant permission for such care to be rendered. I do hereby recognize and understand that the coach(s) is not responsible for any injury of any kind which may occur during participation. Also, **I have read and understand the policies and procedures of SHOT DOC NATION BASKETBALL CAMP.**

X _____ Date _____

Parent/Guardian Signature

Method of Payment: Check CC Cash Total _____