

**Please sign both sides and return to:  
Below The Rim Basketball Camp Inc  
16 Whispering Way  
Stow, Ma 01775  
Tel. No 508 333 5880**

In consideration of my son/daughter becoming a camper at the Below The Rim Basketball Camp Inc (the "camp"), I \_\_\_\_\_ the parent/guardian of \_\_\_\_\_ (please print). Hereby authorize the camp or its representatives to obtain emergency medical treatment on behalf of my son/daughter in the event that, in the opinion of the said camp, my son/daughter is in need of such treatment. I further agree that I will be responsible for the payment of such medical treatment and further release said camp or its representatives for any damages sustained by me in the connection with the providing of emergency medical treatment. The camp agrees to contact the parents or guardian as soon as is reasonably possible after the event which requires said emergency treatment, at the telephone number(s) indicated on the back of this form.

I further agree that I will be responsible for the payment of any cost of medical treatment of any such nature which arise in connection with any sickness or accident which may occur during that period and my son/daughter is at the camp, whether such expense is incurred during or subsequent to the time that my son/daughter attends the Camp and will indemnify and hold harmless the Camp for any claims for payment by the providers of said medical care.

Signature of Parent or Guardian. \_\_\_\_\_

Date \_\_\_\_\_

**Please complete and sign the back of this form. Thank you**

## Student Emergency Information

Please Print:

Student's Name \_\_\_\_\_

Student's Address \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Cell \_\_\_\_\_

Date of Birth \_\_\_\_\_

Name of Parent or Guardian \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Name of Nearest Relative to be notified if parents cannot be reached. \_\_\_\_\_

Address \_\_\_\_\_

Phone Number Home \_\_\_\_\_ Work \_\_\_\_\_

Family Physician \_\_\_\_\_

Phone Number \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_

Phone Number \_\_\_\_\_

Policy Number \_\_\_\_\_

List of Allergies \_\_\_\_\_

Other relevant medical information \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Date of last Physical Examination \_\_\_\_\_

Date Student will be attending camp \_\_\_\_\_

Signature of Parent/ Guardian \_\_\_\_\_

Please check if you do not want photographs of your child on our website or future publications. \_\_\_\_\_

Parents Authorization: This Student emergency information is correct as far as I know, and the person herein described has the permission to engage in all prescribed camp activities, except as noted by me and the examining physician.



