

SATURDAY MORNING BASKETBALL

Please print clearly!

Child/Children's Name(s) _____ Age _____

Address _____

Zip Code _____ Date of Birth _____ Grade _____

Parent/Guardian's Name _____ Relation _____

Home Phone _____ Work Phone _____ Pager/Cell _____

Email (used in the event of a cancelation due to weather) _____

Does your child take any medications, or have any allergies/medical conditions that we should be aware of? If so, please explain: _____

IN CASE OF INJURY, MEDICAL PROFESSIONALS WILL TRANSPORT PARTICIPANT FOR EMERGENCY TREATMENT AS SOON AS POSSIBLE. PLEASE INFORM EMERGENCY CONTACT PERSONS OF THIS INFORMATION IN CASE OF EMERGENCY. WE WILL TREAT ALL EMERGENCIES IMMEDIATELY AND NOTIFY PARENT OR GUARDIAN AS SOON AS POSSIBLE.

****Please list emergency contacts in order of priority, keeping in mind the hours of 8:30 AM to 12:00 PM.****

| | Contact Person | Relation | Phone Number |
|----|----------------|----------|--------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Please check when your child will be attending.

PARK VIEW M.S.

Grades 3-5: _____

Grades 6-8: _____

WESTERN HILLS M.S

Grades 3-5: _____

Grades 6-8: _____

COMMUNITY YOUTH CENTER

Grades K-2 (9:00am Session): _____

Grades K-2 (10:30am Session): _____

Signature _____ Date _____

Date paid: _____ Amount paid: _____ Method: _____