2009 Application for the Maine Red Claws Camps
413 Congress Street
PORTLAND, ME 04101
(207) 210-6655
Fax: (207) 210-6659

Please check the camp(s) you are applying for this summer:

☐ **Jr. Red Claws Camp (Ages 8-11)**

☐ **Red Claws Basketball Academy (Ages 12-17)**

Name _____

Address _____

City, State, Zip _____

Phone- Home( ) _____ Work( ) _____ Cell( ) _____

Age by Sept. 1ST _____ Height _____ T-Shirt Size _____

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.

PLEASE MAKE CHECKS PAYABLE TO THE MAINE RED CLAWS
Please enclose your deposit or full payment with this application and mail to the address above. Your cancelled check(s) will be your receipt.

PARENT'S or GUARDIAN'S SIGNATURE

Date_____/_____/_____

DEPOSIT for Jr. Red Claws Camp $50
DEPOSIT for Red Claws Basketball Academy $50
FULL PAYMENT of $175 for Jr. Red Claws Camp must be received by Aug 14th
FULL PAYMENT of $250 for Red Claws Basketball Academy must be received by Aug 14th

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_____

Rev 06/09

HEALTH HISTORY: (Check, giving approximate dates)

Ear Infections	**Allergies:**	**Diseases:**
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 the MAINE RED CLAWS, MAINE BASKETBALL LLC, and 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 MAINE RED CLAWS, MAINE BASKETBALL LLC, and 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(_____)_____-_____