

Camp \_\_\_\_\_ Camper Name \_\_\_\_\_  
Date \_\_\_\_\_ Social Security Number \_\_\_\_\_

**PARENTAL CONSENT AND WAIVER OF RESPONSIBILITY**

In consideration of the Noah Dahlman Basketball Camps LLC acceptance of,

\_\_\_\_\_, as a student in sports camp for the period in the dates mentioned above.

It is agreed that all risks attendant to watching and/or participating in camp activities including, but not limited to bodily injury, are assumed by the student and his parents and/or legal guardian and that this assumption is acknowledged, approved, and agreed to by said student and his parents and/or legal guardians as indicated by their signature hereto.

I hereby grant permission for physicians, dentists, other licensed health care providers and their designees to administer outpatient medical, surgical, or dental services as appropriate, or necessary antigens or other injections, to perform emergency procedures as necessary or to refer to duly licensed medical personnel when indicated.

\_\_\_\_\_ Parent or Legal Guardian Signature / Date

**IMAGE RELEASE**

In consideration of \_\_\_\_\_, my minor child being allowed to participate in any way in ND42 Basketball Camps related events and activities, the undersigned agrees that such participant's likeness may be photographed or videotaped and that such image may be published in an outlet used to promote or publicize the program.

\_\_\_\_\_ Parent or Legal Guardian Signature / Date

**MEDICAL CLEARANCE**

I hereby certify the named camper is physically able to participate in ND42 Basketball Camps and that I know of no physical impairments which would in any manner limit his/her participation in such program.

\_\_\_\_\_ Parent or Legal Guardian Signature /Date

**MEDICAL INFORMATION**

Hospitalization Plan:

Claim No. \_\_\_\_\_ Company \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Code \_\_\_\_\_ Phone \_\_\_\_\_

**\*FRONT AND BACK COPY OF INSURANCE CARD SHOULD BE INCLUDED AT TIME OF CHECK-IN\***

Medical History (if pertinent):

\_\_\_\_\_  
Allergies, present medication, special considerations:

\_\_\_\_\_  
Parent/

Guardian \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Code \_\_\_\_\_

**EMERGENCY MEDICAL INFORMATION**

NAME \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_

PHONE CELL \_\_\_\_\_