



APPLICATION FORM

Player's Name: _____

Address: _____ **City:** _____

E-mail: _____

Date of Birth: _____ **OHIP#** _____

Phone#: _____ **Cell Phone#:** _____

Name Parent/ Guardian: _____

Basketball experience: _____

Please list any illness that your child has, such as asthma, heart disorders, allergies, etc.:

Please list any prescribed medication that your child is taking and note if and when he/she must take it during the hours of the basketball program.

I understand that this basketball program will be physically demanding and to the best of my knowledge, my above named son/daughter or other is in good health. I also understand and agree except for basic first-aid treatment, SUMMIT Basketball Training Program /SUMMIT Health & Fitness Club will accept no responsibility or liability for accident or illness incurred by a participant/player during the program. I have hereby give my approval for emergency medical treatment, if required. I also agree to have current health insurance coverage for the above named participant. I will in no way hold responsible SUMMIT Basketball Training Program or SUMMIT Health & Fitness Club, or anyone associated with, for medical or dental accidents.

Name of Parent/Guardian (please print): _____

Signature of

Parent/Guardian: _____ Date: _____