



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. 1<sup>ST</sup> \_\_\_\_\_ 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 14<sup>th</sup>

FULL PAYMENT of \$250 for Red Claws Basketball Academy must be received by Aug 14<sup>th</sup>

# 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.		
Pevnar: 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	<b>Allergies:</b>	<b>Diseases:</b>
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(\_\_\_\_)\_\_\_\_-\_\_\_\_\_