Red Auerbach International Basketball School
14 Temple Street #7F Framingham, MA 01702

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 O No O (If Yes, state type and date of exposure_____

Rev 02/03

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

**** THIS FORM MUST BE SIGNED FOR FULL PARTICIPATION ****

By enrolling player, I ensure that such individual is physically and mentally able to participate in all of the camp's activities. I understand 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 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(_____)_____-_____*

Rev 12/05

*****PLEASE SUBMIT THIS COMPLETED FORM WITH $200 DEPOSIT OR TOTAL PAYMENT*****

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14 Temple Street #7F Framingham, MA 01702

Auerbach Basketball School COVID Attestation Form

This Form is to be completed and submitted by a parent/guardian

Dear Parent/Guardian:

Due to the high-risk nature of the sport of basketball and associated drills and sessions within a camp setting, parents/guardians are asked to sign off on the following acknowledgment. No student-athlete will be allowed to participate in any part of Auerbach Basketball School unless this form is submitted. Thank you for your understanding and cooperation.

- - -

Parent/Guardian Last Name: _____ Parent/Guardian First Name: _____

Email Address: _____ Phone: _____

Student-Athlete's Last Name: _____ Student-Athlete's First Name: _____

Student-Athlete's Grade/Age: _____

COVID-19 Certification (please read and acknowledge)

By signing below, I am certifying that each day I send my child to a practice/competition, they have been free of COVID-19 symptoms (see symptom list below) for the past 24 hours. I am also certifying that my child has not been asked to quarantine or isolate by a public health official and that, to my knowledge, they have not been in close contact with anyone who has tested positive for COVID-19, or has been experiencing COVID-19 symptoms.

COVID-19 Symptoms

- Fever (100° Fahrenheit or higher), chills, or shaking chills
- Cough (not due to other known cause, such as chronic cough)
- Difficulty breathing or shortness of breath
- New loss of taste or smell
- Sore throat
- Headache, when in combination with other symptoms
- Muscle aches or body aches (not related to athletic activity)
- Nausea, vomiting, or diarrhea
- Fatigue, when in combination with other symptoms
- Nasal congestion or runny nose (not due to other known causes, such as allergies), when in combination with other symptoms

Parent/guardian signature: _____ Date: _____