Wayne Buckingham Basketball Summer Camp

BOYS & GIRLS SUMMER BASKETBALL CLINIC

Monday, July 24ST - Thursday July 27th

2017 CLINIC APPLICATION

TAKING YOUR GAME TO THE NEXT LEVEL...

Coaching from Former NBA & WNBA PLAYERS

AGE GROUP: Grades 1-8

LOCATION: Fort McClellan Aquatic & Fitness Center
130 Summerall Gate Road, Anniston, AL 36205

Date: July 24-27 TIME: 9:00 a.m. to 2:00 p.m.

COST: $40.00 **(lunch and camp t-shirt will be provided)**

PHONE: Information call Stephanie Almon at 678-729-7237 or Coach Buckingham at 331- 472-9828

2017 CLINIC BASKETBALL APPLICATION

Participant's Name:_____ Age:_____ Grade: _____

Family Address:_____ City: _____

State:_____ Zip Code:_____ Email Address:_____

Parents or Guardian's
Name:_____

House Phone #:_____Father's Cell Phone #:_____Mother's Cell Phone #:_____

Participant's School Name:_____

School Address:_____

Insurance's Company Name: _____ Policy Number: _____

Participant's Shirt: Small ☐ Medium ☐ Large ☐ X-Large ☐ XXL ☐ **Check One: Youth Shirt __ Adult Shirt__**

The undersigned parent or guardian understands that the applicant will be engaging in physical activity during the program which contains an inherent risk of physical injury, and the undersigned assumes this risk and releases the Wayne Buckingham's W.A.B. Sports; and Associates, their officers, directors, consultants and employees; and Cascade Junior Pro from any and all liability for personal injury arising out of the applicant's participation in the camp program. I hereby grant permission for my child to be treated by a licensed physician or a member of the athletic training staff for any injury, accident, illness, or other mishap. I further agree to pay through my insurance company or otherwise for any medical treatment that may be necessary. I certify that my child is in good health and is able to participate in all camp activities. I further consent that any pictures, video, or film furnished by me or taken of my child, myself or family members in connection with W.A.B. Sports and Associates may be used by W.A.B. Sports and Associates and all other businesses, enterprises, affiliates and related entities of this business or company or for publicity, promotions, advertisement via television, radio, magazines, digital and online media, or in any other manner they choose. I waive any and all compensation in regards thereto.

Parent/Guardian Signature_____Date_____

COMMITMENT AND EXPECTATIONS

It is understood that W.A.B Sports Clinic, W.A.B Sports & Associates and W.A.B Associates are all known entities of Wayne Buckingham as referred to throughout this registration package.

1) The participant agrees to participate in the W.A.B Sports Clinic and to meet all of its requirements.

2) The participant must follow the program schedule at all times and must be subject to the authority of all W.A.B Associates staff. The participant agrees to abide by the rules of the program and to obey all the laws of the host country.

3) W.A.B Associates and its personnel are authorized to arrange for necessary medical treatment, including hospitalization.

4) The participant / parent legal guardian, agrees to be familiar with the insurance policy that will cover the participant during the entire camp session. It is the responsibility of the participant / parent legal guardian to understand the policy and to pay for any medical treatment and supplies that are not covered by the policy.

5) W.A.B Associates and its personnel are not liable for loss, damage, injury or expenses caused by the participant.

6) The participant / parent legal guardian will compensate for losses and damages resulting from the participant's actions while participating in the program and will make any compensation before departure from the program. If any costs arise after departure (example telephone charges), the participant / parent legal guardian will still be held liable for making compensation.

7) Smoking is not allowed. Drinking or possession of any alcoholic beverages is prohibited.

8) The use of or possession of illegal drugs or any illegal substances are prohibited, and will result in immediate dismissal from camp.

9) Leaving the camp property at anytime without proper supervision or permission is prohibited.

10) If the participant does not follow all the rules set by the W.A.B Associates program, or interferes with the success of the program, W.A.B Associates is authorized to dismiss the participant from the program at any time. The participant will bear the cost. There will be NO REFUNDS.

11) A copy of the participant's current health and medical insurance policy must accompany this application.

By checking the box, I signify that I have read and understand all the above guidelines and conditions and agree to abide by them while in the W.A.B Associates program. We also confirm that the information given on this application is true and complete. We, the participant and parent/legal guardian, hereby grant W.A.B Sports Associates, the Directors, its personnel and any other independent agent of W.A.B Sports Associates, all necessary permissions and authorizations to act as legal guardians and "in loco parentis" in any situation, especially in emergencies whether or not such emergency includes the possibility of surgical procedures or any other medical treatment.

I HAVE READ, UNDERSTAND AND AGREE TO THE COMMITMENT AND EXPECTATIONS OF THIS PROGRAM ☐

Signature of Parent/Legal Guardian:_____**Date:**_____

Signature of Participant:_____**Date:**_____

Athletic Physical Form

Name		Birth date		Grade	School/ Program
Address				Home Phone	
Sport(s)					
Father		Work phone		Mother	Work phone

Please give alternatives to contact in case of emergency in the event neither parent can be reached:

Name	Phone	Name	Phone

Medical history to be completed by parent (must be completed before physical)

	Yes	No		Yes	No
Any past injuries			Presently taking medication		
Fainting or dizziness while exercising			History of head injury		
Allergies			Significant past illness		
Asthma			Orthodontia (braces)		
Wears contact lens/glasses			Any ongoing medical problems		
Past surgical procedures			Seizures		
Any hospitalizations			Bone/joint problems		

Tetanus (date)

Comments on any Yes

Parent/Guardian signature

Physical Exam

Height Weight Blood pressure Pulse

	(Normal)	Comments/Follow-up		(Normal)	Comments/Follow-up
General condition			Gastrointestinal		
Skin			Lungs		
Ears			Genito-urinary		
Eyes			Neurological		
Nose			Musculoskeletal		
Throat			Spinal		
Mouth/dental			Nutritional status		
Cardiovascular			Mental health		

I approve this student's participation in WAB Basketball Sports Clinic for one year YES ☐ NO ☐

Additional comments

PNP Signature Physician Signature

Date Date

Emergency Contact Name_____ **Cell #:**_____**Alternate #**_____

Allergy Log

	Rash	Itching	Hives	Constipation	Diarrhea	Hard to Breathe	Cramping	Scratchy Throat	Runny Nose	Facial Color	Swelling
ANIMALS											
Cats											
Dogs											
Insects											
Other											
MEDICATIONS											
Antibiotics											
Pain Medication											
Anesthetics											
Other											
ENVIRONMENT											
Dust											
Mold											
Cleaning Products											
Pollen											
Grasses											
Trees											
Other											
FOODS											
Shellfish											
Peanuts											
Eggs											
Wheat											
Soy											
Other											
DRINKS											
Juice											
Milk Products											
Other											