AUTHORIZATION OF MEDICAL TREATMENT OR MINORS

_____ _____ _____
Name of Minor Age Date of Birth

_____
Name of Parent/Guardian

_____ _____ _____
Street Address City Zip

Phone: (___) _____ (___) _____
Home Work

Please List Two Additional Contacts in Case of an Emergency (other than parents).

_____ _____ _____
Name Relationship Phone Number

_____ _____ _____
Name Relationship Phone Number

Insurance Information:

_____ _____
Name of Company Policy/Group Number

I/We, being the parent(s) or legal guardian(s) of the above named minor, do herby Appoint the STAFF OF HOOP MOUNTAIN NEW YORK , LLC GIRLS BASKETBALL CAMP, to act in my/our behalf in authorizing emergency medical, dental, surgical care and Hospitalization for the above mentioned minor during the following period of Hoop Mountain New York, LLC Girls Basketball Camp:

_____ _____
Camp Month/Date/Year to Month/Date/Year

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as emergency medical, dental, surgical care or hospitalization may be required.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

This medical form must be completed in full with accurate information. ***It must be received at least two (2) weeks prior to the beginning of camp.***

Please return all medical forms to:
Beth Costello (Hoop Mountain Health Director)
137 Davis St.
Painted Post, NY 14870

For questions concerning medical forms please e-mail Beth Costello at:
erc0426@yahoo.com