

In consultation with The American Medical Association and the American Academy of Pediatrics

10 FEET UP BASKETBALL SKILLS CLINIC HEALTH FORM

Name _____ Birth Date _____ Sex _____ Age _____

Parent or Guardian (or Spouse) _____ Phone _____

Home Address _____

If NOT available in an EMERGENCY, please notify:

1. _____ Phone _____

Address: _____

2. _____ Phone _____

Address: _____

HEALTH HISTORY: (Check and give approximate dates if applicable only)

_____ Ear Infection _____ Rheumatic fever _____ Convulsions _____ Diabetes

_____ Loss of Paired Organ _____ Epilepsy _____ Glasses/Contacts

_____ Hearing Impairment

Dates: _____

ALLERGIES (Check applicable)

_____ Hay Fever _____ Ivy poisoning, etc. _____ Insects _____ Penicillin

_____ Other Drugs (List: _____)

DISEASES (Check applicable and give approximate dates)

_____ Chicken Pox _____ Asthma _____ Cancer/Leukemia

Dates: _____

List any medications currently taken _____

Surgeries or Serious Illnesses (Date & Type) _____

Chronic or Recurring Illness _____

Other diseases or details of above _____

Any Specific Activities to be:

Encouraged? _____

Avoided? _____

Due to New York State Health Department regulations, we need dates of immunizations against the following:

Diphtheria _____ Haemophilus Influenza Type B _____ Hepatitis B _____

Measles _____ Mumps _____ Poliomyelitis _____ Rubella _____ Tetanus _____

Varicella (Chicken Pox) _____

Dates: _____

*If your child has not been immunized for any of the above please state why (religious reasons, too young, etc.) _____

IMPORTANT: Please notify the camp if the camper has been exposed to any communicable diseases during the three weeks PRIOR to camp attendance.

Suggestions from Parent/Guardian _____

Physician Name _____ Phone _____

HEALTH INSURANCE INFORMATION

Company _____

Policy Holder Name _____

PLEASE SIGN!!

PARENTS AUTHORIZATION

This Health History is correct as far as I know and the person herein described has permission to engage in all prescribed activities, except as noted by me.

Signature _____ Date: _____

In the event I cannot be reached in an EMERGENCY I hereby give permission to the physician selected by the camp director to secure proper treatment for my child as named above.

Signature _____ Date: _____

10 FEET UP LLC BASKETBALL CLINIC – MEDIA WAIVER

I, Parent/Legal Guardian of (child's name) _____
hereby grants permission to 10 Feet Up LLC to photograph, take motion pictures,
take video footage, and/or make electronic sound recordings of the above named
child (herein referred to as photographic or electronic reproductions).

I authorize the use of any such photographic or electronic reproductions of the
above named child for any purpose, including, but not limited to educational and
other public media as may be deemed appropriate by 10 Feet Up LLC (I understand
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I further acknowledge that I will not be compensated for these uses and 10 Feet Up
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without limitation claims of defamation or invasion of privacy, or of infringement
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Date

Parent/Legal Guardian Signature

Printed Name