2019 PURDUE BASKETBALL CAMPS

REGISTRATION FORM

Camper's Name _____ Gender _____ D.O.B. _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ School _____ Grade (as of Fall 2019) _____

Roommate Name (If Residential Camper) _____

Printed Name of Parent/Legal Guardian (required) _____ E-mail _____

PLEASE CHECK SPECIFIC CAMP AND CATEGORY

PARENT/CHILD - JUNE 8 - $210 (add $75 for each additional child) # of children (☐ $210) _____ x $75 = _____

Participating Parent / Family Member Name _____

		COMMUTER	RESIDENTIAL
NEXT LEVEL I - JUNE 9-12		☐ $350	☐ $490
NEXT LEVEL II - JUNE 16-19		☐ $350	☐ $490
DAY CAMP (GRADES 1-2) - JUNE 24-27	☐ Male ☐ Female	☐ $140	
DAY CAMP (GRADES 3-9) - JUNE 24-27	☐ Male ☐ Female	☐ $270	

PAYMENT METHOD
Payment is due upon submission of registration. Make payment by Check or Money Order (payable to Matt Painter Basketball Camps LLC):

CREDIT CARD PAYMENT
If paying with a credit card, please register online at:
PurdueBasketballCamps.com

Duplicate this application as needed and return to:

Matt Painter Basketball Camps LLC
P.O. Box 2885
West Lafayette, IN 47906

Or Fax with credit card information to 765.496.1388

PARENT AUTHORIZATION

PARENTAL AUTHORIZATION FORM AND PHYSICIANS PHYSICAL

Prior to any camper participating in camp, a copy of a physicians' examination and/or a parental authorization must be received. PARENTAL AUTHORIZATIONS MAY BE SIGNED AT REGISTRATION OR SENT IN AHEAD OF TIME. A COPY OF A PHYSICAL USED FOR SCHOOL OR OTHER ATHLETIC EVENTS ARE PERFECTLY ACCEPTABLE AS LONG AS IT WAS ADMINISTERED IN THE LAST 365 DAYS. The physician may also sign the form below any time within the last 365 days prior to the start of camp. Please call 765-494-6693 with any questions or concerns about proof of physical or parental authorization.

PURDUE UNIVERSITY MEDICAL AUTHORIZATION FOR TREATMENT OF A MINOR PERSONS UNDER 18 YEARS

Pursuant to Indiana Code Paragraph 16-36-1-6, I request and authorize the Purdue University Student Health Center, Purdue University Ambulance Service, Clarian Arnett Health Hospital, and St. Elizabeth East Hospital medical personnel, agents, and employees to provide all reasonably necessary medical care advisable for the health of my child, including but not limited to medical transport, hospital tests, such as pathology, radiology, anesthesia, evaluation and treatment by physicians, including surgery, and prescription drugs. I acknowledge that no representations, warranties, or guarantees can be made with respect to any medical care or treatment provided.

I also understand that, as a result of my child's participation in this program, it will be necessary for supervisors, coaches, residence hall personnel, and others involved with the program to have access to relevant medical information pertaining to my child, and I authorize the use and disclosure of my child's medical information to promote a safe and healthy experience for my child.

Further, I hereby grant permission for my child: _____
Minor's Name Date

To attend the 2019 Purdue Basketball Camp, a signature from one or both parents/legal guardians and a witness signature is required.

_____
Signature (Parent/Legal Guardian - required)

_____
Signature (Parent/Legal Guardian/Witness - required)

EMERGENCY CONTACT(S)

Primary Contact Name: _____

Relationship to Camp Participant: _____

Day Phone: _____

Evening Phone: _____

EMERGENCY CONTACT(S)

Secondary Contact Name: _____

Relationship to Camp Participant: _____

Day Phone: _____

Evening Phone: _____

Consent for Medical Treatment of a Minor

Name of Minor:_____ Date:_____

In order to enable the Purdue Basketball Camps to provide prompt care to your

minor son or daughter, we urge you to read and complete this Consent form. In this way, we can help your child without delay should an emergency occur.

I, _____,
(Full name of parent/guardian)

declare that I am the_____
(Father/Mother/Guardian)

of _____
(Full name of minor)

a minor, age _____, born_____, 19_____

Please provide the following information concerning said minor:

Allergic Reactions: _____

Present Medication(s):_____

Date of Last Tetanus Booster: _____

Any past illness or other information that would be useful in the event medical treatment is necessary:

_____

Please complete ONE of the following:

- ☐ I grant permission of the camp directors, assistants, or other persons responsible for his/her care to act on my behalf for said minor in granting permission for evaluation and treatment of medical or psychological problems. In the event that I cannot be reached, I hereby give my consent to such medical treatment as deemed necessary, including surgery, lab tests, x-ray examinations and physical therapy to be rendered to said minor by a licensed/certified health care provider.

Date:_____ Signature:_____
(Parent or Guardian)

- ☐ I do not wish medical care of any kind except emergency care to be provided for said minor.

Date: _____Signature: _____
(Parent or Guardian)