



BASKETBALL CAMP

July 11th–15th, 2016

9:00am — 3:00pm

Boys & Girls—K- 8th Grade

\$225.00 per player

Fundamentals



Games



Skill Development

*Please make all checks payable to:
Super League Athletic Academy*

*Limited Spots Available!
Reserve Immediately!*

*For more information contact:
Mr. James Pristouris
Superleagueathleticacademy@gmail.com*

*Each Parent Must Sign A Waiver
Form in Order to Participate.*

*Location: Dimitrios and Georgia Kaloidis School
8502 Ridge Boulevard Brooklyn, 11209*

\$25 Discount for additional sibling

*Each Camper Will Receive a S.L.A.A.
T-shirt and Camp Picture.*

Child's Name: _____ Age: _____

Parent's Name: _____

Address: _____ Telephone: _____

Cell: _____ Email: _____

Emergency Contact/Relation to Camper: _____ Phone: _____

I do hereby agree to release, discharge, and hold harmless Sunset Youth Center, Inc. & Super League Athletic Academy its officers, coaches, staff, and all agents from all causes, liabilities, damages, or claims or demands whatsoever on account of any injury or accident involving my child arising from attendance or in the course of the competition and/or activities held in connection with the camp. I do hereby grant permission for Sunset Youth Center, Inc. & Super League Athletic Academy to photograph my child and use images for promotional materials, advertisements and publication purposes.



Super League Athletic Academy Medical Form



Medical Certificate

Child Information

Name _____ Camp Session _____
 Address _____
 City/State/Zip _____ DOB, Month/Date/Year _____

Emergency Information

In case of accident or serious illness the camp director will contact the parents. If we are unable to reach you, please give the name of a physician we may call for instructions. Also list two emergency contacts that will assume temporary care of your child if you cannot be reached.

Parent (s) or Guardian (s)

Father _____	Mother _____
Occupation _____	Occupation _____
Company _____	Company _____
Business Address _____	Business Address _____
Business Phone _____	Business Phone _____
Physician's Name _____	Phone _____
Address _____	

Emergency Contact (s)

Name _____ Relationship to child _____
 Address _____ Phone _____

Name _____ Relationship to child _____
 Address _____ Phone _____

It is understood that in the final disposition of an emergency case, the judgment of the camp authorities will prevail if none of the above can be reached by phone. In the event that a representative of the camp is unable to reach me, I give refuse permission for any necessary treatment or surgery to be performed in the case of a serious emergency.

Signature of Father _____

Signature of Mother _____

Health Insurance

Insurance Company _____ Policy Number _____
 Camper's SS # _____ Policy Holder's SS # _____

Medical Information and History (to be completed by physician)

Has anyone in your family under age 45 died suddenly	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Serious illness or any illness for more than 10 days	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been told not to play a sport because of your health	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have or have you had any orthopedic defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Have you ever had:

Concussion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any operations or hospitalizations	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Easy Bruising or Bleeding Tendency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heat Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures or Convulsion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Head or Neck Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bee Sting Allergy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Very bad vision in one or both eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing loss or deafness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart trouble or murmurs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Perforated ear drum	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Draining Ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Coughing lasting more than 3 weeks	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sinus Problem or hay fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chest pain or faintness w/ exercise	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Braces or removable false teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any broken bones	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dislocation/other serious problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Serious Foot Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you wear glasses or contacts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back injury or frequent backaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you take any medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ankle or knee injury or problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you smoke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other joint problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Boys: Any problem with testicles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If "Yes" was answered to any of the questions above, please provide explanation:

Physical Examination- a complete physical examination is required for all children.

Height _____ Weight _____ Blood Pressure _____

Vision Uncorrected L 20/ _____ R 20/ _____ Vision Corrected L 20/ _____ R 20/ _____

Skin	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Lungs, Chest	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Eyes	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Spine	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
ENT	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Abdomen	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Mouth and Teeth	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Genitals(Hernia)	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Neck	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Extremities	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Cardiovascular	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Orthopedic	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Allergies	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Neuromuscular	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Other tests	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Assessment	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

If "Abnormal" was answered to any of the questions above, please provide explanation:

Special Conditions for Participation (e.g., pre-exercise medication or protective equipment, if any):

I have examined the child named above, reviewed his/her health history and found that he/she is physically fit and able to participate in sports, except as noted above.

Physician's Signature _____

Date _____

Physician's Address _____

Physician's Phone _____

Physician's Stamp

Parental Permission for Participation in Super League Athletic Academy Camps

I give permission for _____ to participate in all Athletic Programs.

Signature _____ Relationship _____ Date _____