

Basketball Clinic with Coach Akeem Scott

**JULY 20-22**

Drop Off/Registration: 8:30-9 Clinic: 9-12 Pick-Up/Lunch (optional):12-1

Please mail form and payment to Hope Hill Youth Services, ATTN: Clinic, 700 Hope Hill Rd. Hope, KY 40334. It is recommended that each participant bring their own basketball.

PARTICIPANT CONTACT INFO:

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Emergency Contact Phone Number

Does your child have any allergies? Y/N If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Concerns/Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Waiver\*

By signing below, I acknowledge that I am the parent or legal guardian of the participant on this form. I also acknowledge that the participant assumes all risks with participation in the Hope Hill Basketball Clinic. Family Connection Inc. d/b/a Hope Hill Youth Services nor any staff assumes liability for incidental injury or damages arising from participation in this program. Due to the strenuous nature of some activities, it is encouraged for participants to consult with a physician for any health concerns before participation. The participant will be responsible for the administration and storage of medications brought to clinic. The participant consents to emergency treatment if needed, and parents/emergency contacts will be notified if treatment is necessary. The participant consents to Hope Hill Youth Services’ use of any photographs or videos taken during the program. The parent or guardian approves of his or her participation in the program by signing below. Instructors and staff are not responsible for children prior to the start of the program or after.

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Guardian Name (Printed)

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Guardian Signature Date