**Hoop and Bat for Mental Health Wellness**

Fill out the form given below completely. Make sure all the information is correct to the best of your knowledge.

|  |  |  |
| --- | --- | --- |
| Date |  |  |
| First Name/Last Name |  |
| Address |  |
| City/STATE/Zip |  |
| Gender |  |
| Date of Birth |  |
| Email |  |
| Major illness |  |
| Allergies |  |
| Disability or level of injury |  |
| Physician/Clinic  |  |  |

Emergency Contact Information

|  |  |  |
| --- | --- | --- |
| Relationship |  | Contact number |
|  |  |
| 2- |  |
| 3- |  |
| 4- |  |
| 5- |  |
|  |
|  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |
| --- |
| Please choose what sessions you would like to attend (sessions are 4 weeks) please put a X; session availability is not guaranteed (N/A means not available at this time) |
|

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Programs  | March | April | May | June | July | August | September | October |
| 1.Basketball |  |  |  |  |  |  |  |  |
| 2.Baseball | N/A | N/A | N/A | N/A | N/A |  |  |  |
| 4. Youth Mentoring |  |  |  |  |  |  |  |  |
| 5. Family Support |  |  |  |  |  |  |  |  |
| Immigration Services |  |  |  |  |  |  |  |  |

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**OFFICE USE ONLY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Form# |  | Accepted |  | Date |  |
| Comment: |  |