



PO Box 1232
 Anna, Texas 75409
 Office (214) 385-7733
www.aboveallthings.org

Welcome to Above All Things Basketball Camp! We serve youth ages 6 -18 years providing them with skills in fundamentals, agility, teamwork, nutrition and so much more! Please complete all requested information below. Incomplete applications will not be accepted and youth will not be able to attend camp sessions without a completed application from his/her parent/guardian.

CAMPER INFORMATION

1. CAMPER INFORMATION				
Camper's Name		Returning Camper	Yes	No
Date of Birth		Gender		Ethnicity/Race
Address City/Town/Zip				
Name of School		Grade entering in Sept. 2019		
2. HOUSEHOLD/FAMILY INFORMATION				
Parent / Guardian #1				
Name		Primary E-Mail Address		
Home Phone			Cell Phone	
Address (City/Town/State/Zip)				
Place of Employment		Home Phone		
Parent / Guardian #2				
Name		Primary E-Mail Address		
Home Phone			Cell Phone	
Address (City/Town/State/Zip)				
Place of Employment		Home Phone		

Are there any court orders relating to the child's custody or release? Yes No

If yes, please provide a copy of the court order.

EMERGENCY CONTACT INFORMATION

3. EMERGENCY CONTACT/AUTHORIZED PICK-UP INFORMATION (IN ADDITION TO NAMES LISTED ABOVE)				
Name		Relationship		
Phone			Phone	
Name		Relationship		
Phone			Phone	
Name		Relationship		
Phone			Phone	



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Photography | Videography | Social Media, Etc. Release

As the parent of a child _____ participating in Above All Things camp

I hereby authorize Above All Things the following:

- I grant ABOVE ALL THINGS permission to photograph/video record my child whose name is listed above while involved in activities at ABOVE ALL THINGS.
- I grant ABOVE ALL THINGS permission to use any photographs/video footage/voice recordings of my child taken during their activities at
- ABOVE ALL THINGS to be posted on ABOVE ALL THINGS 's website, Facebook, brochures, flyers or any other publication. (When names are added, only first names will be used.)
- I understand that I have the right to request, in writing, to have a photo removed from the website or Facebook within 30 working days.
- I understand that all rights, title and interest in the photography or videography obtained belongs to the Above All Things.
- I understand all rights, title and interest belong to Above All Things and that I will receive no financial compensation for the use of these photos and/or video.
- Above All Things may edit, copy, alter or revise the photos/video as they see fit.
- Above All Things will retain control over the use and distribution of the photographs/video.

(Check one) I **AGREE** to all terms and conditions of this release
 I **DO NOT AGREE** to all terms and conditions of this release.

Name of Parent/Guardian (please print)

Date:

Signature of Parent/Guardian:

Student Name



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Waiver of Liability

ABOVE ALL THINGS recommends that all youth have an examination by a licensed physician prior to participating in ABOVE ALL THINGS -sponsored activities. The purpose is to discover any condition which would make it dangerous for the child to participate in strenuous ABOVE ALL THINGS -sponsored activities and to protect other participants from communicable diseases.

I hereby waive any liability that the ABOVE ALL THINGS its officers, directors, trustees, agents, volunteers, or employees might have for, and agree that said ABOVE ALL THINGS , its officers, directors, trustees, agents, volunteers, and employees shall not be liable for any bodily injury to me incurred while I am practicing for, or participating in, any contest or exhibition of an athletic or sports nature sponsored by the ABOVE ALL THINGS , and I hereby assume the risk of any bodily injury incurred by me while practicing for or participating in any contest or exhibition of an athletic or sports nature sponsored by the ABOVE ALL THINGS .

I hereby give my permission for my child to participate in the full ABOVE ALL THINGS -sponsored program, and, to the best of my knowledge, my child has no physical conditions which will make it dangerous for him/her to participate in ABOVE ALL THINGS -sponsored program activities.

In consideration of admittance I authorize the ABOVE ALL THINGS to arrange for medical examination and/or treatment for my child should an emergency arise at the while at the any of the Greater Providence ABOVE ALL THINGS.

It is understood that a conscious effort will be made by the Director to contact me at the emergency number provided before any medical action is taken

Parent/Guardian Signature

Date



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2019 CAMPER HEALTH HISTORY FORM

CAMPER HEALTH INFORMATION					
Camper's Name		Date of Birth		Gender	
Name of Parent/Guardian Primary Emergency Contact					
Emergency Number		Guardian Date of Birth			
Address City/Town Zip					
If primary contact is not available, in case of an emergency contact					
Name		Relationship			
Cell Phone		Home Phone		Work Phone	

Please check any conditions that your child has experienced.

Food Allergies

Yes No

If yes, please list allergies below:

Other Allergies:

Yes No

Please check if any of the following apply to the child:

Frequent Ear Infections

Heart Defect/Disease

Convulsions

Diabetes

Bleeding/Clotting Disorders

Hypertension

Mononucleosis

Psychiatric Disorders

Seizures

Asthma

Chicken Pox

German Measles

Mumps

Measles



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Please list any medications your camper is currently taking including the dose, prescription and times, an additional medication release form is required. If your camper will need to take medication while at camp, the medication form must be complete.

Does your child have an Epi-Pen? Yes _____ No _____

If yes, please include emergency action plan and indicate below what allergies the epi-pen is used for.

Please list the date and nature of any operations or serious injuries

--

Please describe any disability or chronic or reoccurring illness

--

Please list any activities encouraged or limited by a physician

--

Please describe any dietary modifications or considerations

--

Does Child have IEP or 504 Educational Plan? Yes _____ No _____

If yes, please provide a copy to ensure your child's success!

Physician Information

Name of Physician		Phone	
Preferred Hospital		Hospital Phone #	

IMPORTANT: Please include a copy of your child's most recent immunization record with this form.

Please read and initial items below:

____ This health history is correct, and the person herein described has permission to engage in all prescribed camp activities except as noted.

____ I hereby give permission to the medical personnel selected by the camp director to order routine tests, x-rays, treatment and necessary transportation for the individual named above.

____ In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to secure and administer treatment, including hospitalization, for my child named above.

Parent/Guardian Signature

Date