



Hoop Dreams Basketball Registration Form

Player Profile

Name _____ Date _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip _____

Phone # _____ Email Address _____

School _____ Grade _____ Age _____

Parent or Guardian Information

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Work _____ Cell _____

Email Address _____

Workout Program/Session (check one)

___ JV/Hoop Stars 12 workouts - \$249

___ Varsity - 12 workouts - \$269

___ Winter Package JV - \$649 (3 mo.)

___ Winter Pkg. Var. \$689 (3 mo.)

___ JV/Hoop Stars 8 workouts - \$209

___ Varsity 8 workouts - \$229

___ Team Sessions (min. 8 players/4 workouts) - \$75 each player

___ Private Lessons \$199 (4 sessions)

___ Drop-In (One-Time Session) - \$35



***Hoop Dreams Basketball
Medical Information/Release Form***

Section 1: ASSUMPTION OF RISK: I understand that there are inherent risks of injury with sports activities. I hereby, intending to legally bound for myself, my heirs, and assigns, waive and release forever any and all liability, and all claims for damages against The Hoop Dreams Basketball Program, (hereinafter HD), Thara Kumbeno Memory, and any Instructors, Coaches, Volunteers and/or Employees for any and all injuries and/or losses I/my child may sustain as a result of voluntary participation in any Hoop Dreams activities.

Signature of Parent or Legal Guardian _____ Date _____

Section 2: HD MEDICAL INFORMATION AND TREATMENT RELEASE: If medical care is required for _____ (**player/participant name**) in conjunction with any HD activity or related transportation, and if normal permission is not available in a timely manner, the undersigned authorizes appropriate medical care as deemed necessary by emergency medical personnel, a physician, or the medical facility providing treatment.

RELATED INFORMATION

Name of Parent(s) or Guardian _____

Address _____

City/State/Zip _____

Home Phone _____ Work _____ Cell _____

If Parent or Guardian is not available, Contact _____

Emergency Contact Phone # _____

Family Physician _____ Phone # _____

My child is allergic to: _____

Childs date of birth ____ / ____ / ____

Medical Insurance Company _____ Policy # _____

SPECIAL INSTRUCTIONS

As a parent or guardian of the above named child, please attempt to contact me at the time of the accident or illness without postponing medical treatment.

I HAVE READ THIS ENTIRE RELEASE FORM AND AGREE TO IT:

Signature of Parent or Legal Guardian _____

Date _____