

Neighborhood Intervention Program Participation Form

Child's Name: _____

Parent(s) Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Email Address: _____

N.I.P. Activity intending to participate: _____

DOB: _____ Grade: _____ School: _____

Please Check One: Male Female

Date of Last Physical Examination: _____

Name of Physician and Hospital: _____

Any medical/health issues staff should be aware of?

- Asthma Heart Problem Diabetes Seizures
 High Blood P ressure Physical Handicaps Other

Names of two people to be contacted in the event of an emergency.

Name: _____

Address: _____ Phone: _____

Name: _____

Address: _____ Phone: _____

I certify that my son/daughter is covered by medical insurance and accept responsibility for payment of all medical and related services arising from participation. In addition, I/we being the parents or legal guardians of the participant authorize the Spartan Basketball Program permission to request emergency medical treatment or care as necessary to insure the well being of our dependent.

Signature of parent or legal guardian Date: _____