

**PAYTON SPORTS CAMPS  
BASKETBALL SHOOTING CLINIC APPLICATION  
Summer 2009**

CIRCLE ONE  
BOY – GIRL

Athletes Name Parent's Name \_\_\_\_\_  
Address \_\_\_\_\_

Email Address \_\_\_\_\_

Phone No.(H) \_\_\_\_\_ Phone No.(W) \_\_\_\_\_  
Emergency Person \_\_\_\_\_ Phone No. \_\_\_\_\_

Year In School Next Fall \_\_\_\_\_ SESSION I II III IV  
T-Shirt Adult XL L M S Youth L M S

My child has permission to attend the Payton Sports Camps Basketball Shooting Clinic. I certify that within the past year he/she has had a physical examination and that now he/she is physically able to participate in basketball camp activities without restriction. In event of an illness or injury, I give consent for medical treatment and permission to attending physician to hospitalize, secure proper treatment, and order injections, anesthesia, or surgery. I will be responsible for any medical or other charges in connection with my child's attendance in camp.

I acknowledge that at the Payton Sports Camps Basketball Shooting Clinic my child will participate in a sport that may involve, among other things, physical contact of the body with other persons or objects, including the ground and at the Payton Sports Camps Basketball Shooting Clinic he/she may incur a risk of injury. I specifically waive and give up and release the Payton Sports Camps Basketball Shooting Clinic and staff from liability for any claim for damages which I or my child may have for injuries or illness that he/she may sustain at camp.

Please List Any Medical Conditions or Allergies our staff should be aware of:

---

\*Please make checks payable to: **Payton Sports Camps**  
Mail to:

**Scott Reid – White Rock Physical Education Teacher**  
10 Yuma Trail  
Oak Ridge, NJ 07438  
973-409-4135

Email at [paytonsportscamps@yahoo.com](mailto:paytonsportscamps@yahoo.com)