

**Providence Basketball Camp presented by Keno Davis  
Medical Information  
(Please print all information requested)**

Camper \_\_\_\_\_  
Last Name First Name Middle Name

1. **PERMISSION FOR EMERGENCY TREATMENT:** I hereby grant permission to the PROVIDENCE COLLEGE BASKETBALL CAMP PRESENTED BY KENO DAVIS to hospitalize and secure proper treatment for my son/daughter \_\_\_\_\_ in case of a surgical or medical emergency, major or minor provided, he/she is unable to communicate with me, and when delay might endanger the life or health of my son/daughter.
  
2. **PERMISSION TO PARTICIPATE:** I individually and as the father/mother/or guardian, do hereby give my permission to my son/daughter to participate in the PROVIDENCE BASKETBALL CAMP PRESENTED BY KENO DAVIS, and use the facilities of Providence College in connection with the camp program. In consideration of your enrolling my son/daughter in the program, I agree to indemnify and hold harmless Providence College and all it's trustees, officers, agents and employees from all claims, liability, loss and damage and expense which may in any way arise from my son/daughter's participation in the PROVIDENCE BASKETBALL CAMP PRESENTED BY KENO DAVIS including with limitation, all claims which my son/daughter, his/her parent, or guardian may have for personal injuries to other person which are caused by my son/daughter. To the best of my knowledge and belief, my son/daughter is of sound health and I know of no reason why he/she cannot participate in the program offered by the PROVIDENCE BASKETBALL CAMP PRESENTED BY KENO DAVIS.
  
3. I am aware that the camp's medical insurance will cover only those cost that my own medical insurance does not cover.

Signature \_\_\_\_\_ Date \_\_\_\_\_

4. **Medical**

Camper's Present Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mother's Name & Phone Number \_\_\_\_\_

Mother's Employer & Phone Number \_\_\_\_\_

Medical Insurance Company & Policy Number \_\_\_\_\_

Father's Name & Phone Number \_\_\_\_\_

Father's Employer & Phone Number \_\_\_\_\_

Medical Insurance Company & Policy \_\_\_\_\_

**Nearest Relative or Friend In Case of Emergency If Parent Cannot Be Contacted:**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Family Doctor's Name & Phone Number \_\_\_\_\_

Date of Last Tetanus Shot \_\_\_\_\_ Wear Glasses/Contacts \_\_\_\_\_ Teeth Braces \_\_\_\_\_

Allergies to Medications \_\_\_\_\_

Please list any additional medical information that the camp should be made aware of:

---

---