

# Hooptown - Fall Program 2023

PARTICIPANTS NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY/TOWN \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

AGE \_\_\_\_\_ GRADE \_\_\_\_\_ BOY \_\_\_\_\_ GIRL \_\_\_\_\_

1. PARENT/ GUARDIAN CELL# \_\_\_\_\_

2. PARENT/ GUARDIAN CELL# \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ CELL/HOME# \_\_\_\_\_

**PICK YOUR SESSION** (Please check the session/s your child will be attending)

**6 Tuesday Sessions - \$200 (September 19, 26; October 3,10,17,24)**

**6 Thursday Sessions - \$200 (September 21, 28; October 5,12,19,26)**

**12 Sessions Tuesday and Thursday - \$350**

**Informed Consent and Acknowledgement** I hereby give my approval for my child's participation in any and all activities prepared by Hooptown, during the selected clinics. In exchange for the acceptance of said child's candidacy by this organization. I assume all risk and hazards incidental to the conduct of the activities, and release, absolve and hold harmless this organization. All its respective officers, agents, and representatives from any and all liability for injuries to the said child. In case of injury to said child, I hereby waive all claims against the organization. Including all coaches and affiliates, all participants, sponsoring agencies, advertisers, and, if applicable, owners and lessors of premises used to conduct the event. There is a risk of being injured that is inherent in all sports activities, including basketball. I authorize the Directors of Hooptown Basketball Clinic to act for me, according to their best judgement, in any emergency requiring medical attention. I will be responsible for any medical or other charges in connection with attendance at the clinic.

Please Sign : \_\_\_\_\_  
Parent or Legal Guardian

Checks: Payable to David Fazio/Hooptown

Mail to Hooptown  
PO Box 1542  
Andover, MA 01810