**2025**
**CAMP APPLICATION**
**PAGE 1**

# WESTERN NEW ENGLAND
# BASKETBALL CAMP

**CAMP DATES ATTENDING**
**□ 7/21-7/25**
**□ BOYS □GIRLS**
**□ 7/28-8/1**
**□ BOYS □GIRLS**
**CAMP TUITION: $310**

*According to Massachusetts General Law 105 CMR 430.000 ALL CAMPERS MUST SUBMIT, IN COMPLETION, BOTH SIDES OF THIS HEALTH FORM **or a Health Care Recommendation form by a Licensed Medical Provider.**

***Camp 8:45-3:45pm***

***NOTE!*** **INDICATE T-SHIRT SIZE**: □YL □AS □AM □AL □AXL

SECTION I (to be completed by Parent/Guardian) **Grade Entering FALL 2025 (Boys & Girls 3rd-9th):** ___________

Email Address:______________________________________________ *All Camp Correspondence will be sent by email - Please PRINT

Name:_____________________________________________________________ Birth Date:_______________________
First Middle Last Month Date Year

Address:_____________________________________________ City:___________________________ State:_________ Zip:_______________

Guardian Is: Father_______Mother________Other_____________Guardian Name:_________________________________________________

Guardian Phone: (Day)________________________________________ Guardian Phone: (Evening)______________________________________

Guardian Address (if different)___________________________________________ City____________________ State_________ Zip_____________

In case of illness or emergency the name and telephone number of a person to contact: (Relative of Participant)

Name:_____________________________________________ Relationship:______________________ Telephone Number: ___________________

## SECTION II: Family Physician or HMO:

Name:______________________________________________________ Address:_______________________________________________

City:____________________________________ State_____________ Zip____________ Telephone: (Day)______________________________

Family Dentist:

Name:______________________________________________________ Address:_______________________________________________

City:____________________________________ State_____________ Zip____________ Telephone: (Day)______________________________

## Medical Insurance Company: ***REQUIRED – NOTE! PLEASE SIGN BOTH SECTIONS BELOW!!!***

Company:______________________________________________________ ***Policy Number:___________________________________________

In case of medical emergency, I hereby give permission to the Camp Certified Athletic Trainer to hospitalize, to secure proper treatment for, and/or to order injection or minor surgery for my child as named above.

_______________________________________________
**Parent Signature REQUIRED ABOVE Date**

SECTION II: CAMP ACTIVITIES AUTHORIZATION
I/We, the undersigned, for ourselves, our heirs, executors, and administrators, waive, release and forever discharge The Western New England Basketball Camp, - Western New England University, and its staff, officers, agents, employees, representatives, successors, and assignees of and from all rights and claims for damages, injuries, or loss of person or property which may be sustained or occu r during participation in Camp activities or while at camp.

_______________________________________________
**Parent Signature REQUIRED ABOVE Date**

**Please Print and Complete BOTH (2) PDF Application Forms**

**A $100 nonrefundable deposit made payable to "Western New England Basketball Camp" must accompany this application.**

**Mail application to: Western New England Basketball Camp 22 Wisteria Lane East Longmeadow, MA 01028**

**Method of Payment Cash or Check – No personal checks accepted on day of registration**

**2025**
**CAMP APPLICATION**
**PAGE 2**

# WESTERN NEW ENGLAND
# BASKETBALL CAMP

*According to Massachusetts General Law 105 CMR 430.000 ALL CAMPERSMUST SUBMIT, IN COMPLETION, BOTH SIDES OF THIS HEALTH FORM **or a Health Care Recommendation form by a Licensed Medical Provider.**

## SECTION III: Physical Examinations

(Must have been done by a medical provider within the preceding 24 months).

Medical History: (Please note significant disorders)

Allergies_______________Heart________________Tuberculosis____________________

Kidney________________Lung________________Diabetes________________________

Varicella_______________Disabilities_____________Neurological_________________

Whooping Cough________________Other:________________________________________

Pertinent Medical History:________________________________________________
__________________________________________________________________________

Child Name:___________________________________________________________Birth

Date:____________________________________________________________ Summary of Significant Treatment Program including Names/dose of Medications to be used while at program:

(Medications MUST be in a container with the original label)

Health Care Provider/Physician:

__________________________________________________________________________

Signature and /or Stamp Required

Date:_____________________________________________________________

Printed Name:______________________________________________________

Address:__________________________________________________________

City:_____________________________________________________________

State____________Zip____________Telephone: (_______) _____________________

Person herein described has permission to engage in all prescribed camp activities EXCEPT as noted here.

## SECTION IV: Immunizations

Has completed primary series of tetanus/diphtheria? (four doses)Yes_________No______________

Primary Series - Type of Vaccine OVP IPV E-IPV_______/_____/______

Laser Booster - Type of Vaccine OVP IPV E-IPV_______/_____/______

| Immunization | Dates |
|---|---|
| Diphtheria/tetanus (Td) | |
| Must be within last ten years | ______/______/______ |
| Measles #1 (Rubella, Red measles) | |
| Must be AFTER age 12 months or | ______/______/______ |
| MMR #1 | |
| or | |
| Positive Measles Titer (Blood Test) | ______/______/______ |
| Measles #2 (rubella, Red Measles) | |
| Must be at least 30 days AFTER first dose | ______/______/______ |
| or | |
| MMR#2 | ______/______/______ |
| Mumps or MM#1 | ______/______/______ |
| Must be AFTER age 12 months | |
| or | |
| Positive Mumps Titer (Blood Test) | ______/______/______ |
| Rubella (German Measles) or MMR #1 | ______/______/______ |
| Must be AFTER age 12 months | |
| or | |
| Positive Rubella Titer (Blood Test) | ______/______/______ |
| Hepatitis B - those born AFTER 1-1-92 | |
| Dose #1 | ______/______/______ |
| Dose #2 | ______/______/______ |
| Dose #3 | ______/______/______ |

Medical Exemption: The above-named person does not have one or more of the requiredimmunizations because she/he has medical problem (s) that precludes the ______ ______________________________________vaccine (s)

| We Provide | You Supply |
|---|---|
| Experienced Coaches • Indoor facilities • Lunch • T-shirt for Every Camper* • Certified Athletic Trainer on Staff • Swimming Pool with Life Guards on duty • | An attitude to Learn! • Sneakers • Swim Gear and Towel |

**Please Print and Complete BOTH (2) PDF Application Forms**

**A $100 nonrefundable deposit made payable to "Western New England Basketball Camp" must accompany this application.**

**Mail application to: Western New England Basketball Camp 22 Wisteria Lane East Longmeadow, MA 01028**

**Method of Payment Cash or Check – No personal checks accepted on day of registration**

**Please Print and Complete BOTH (2) PDF Application Forms**

**A $100 nonrefundable deposit made payable to “Western New England Basketball Camp” must accompany this application.**

**Mail application to: Western New England Basketball Camp 22 Wisteria Lane East Longmeadow, MA 01028**

**Method of Payment Cash or Check – No personal checks accepted on day of registration**