

SJCC Coach Brown's Basketball Skills Clinics

Childs' Name _____

Address _____ Postal Code: _____

Birthday :(D/M/Y) _____ Home Phone: _____

Parent Name: _____

Cell Phone: _____ Work Phone: _____

Work Address: _____

Email: _____

Parent Name: _____

Cell Phone: _____ Work Phone: _____

Work Address: _____

Email: _____

Alternate Contact:

Name: _____ Relationship: _____

Cell Phone: _____ Work Phone: _____

Doctor's Contact Information:

Health card number (optional) _____

Doctors Name: _____ Phone Number: _____

Doctors Address: _____

Does your child carry an Epipen Yes _____ No _____

Does your child have an inhaler? Yes _____ No _____

Does your child have any allergies of health conditions? Yes _____ No _____

If so please describe:

Parent Signature: _____ Date: _____