



"MISSING LINK" BASKETBALL CAMP FORM



SELECT ONE (OR BOTH) OF THE 2 CAMPS LISTED. THEN SEND IN THIS
COMPLETED FORM WITH FULL PAYMENT TO:

Coach Ron Link * 130 Green Top Way * Athens, GA 30605

- OR -

DROP THIS FORM OFF IN THE ACS OFFICE WITH A CHECK MADE OUT TO: COACH RON LINK

Camp #1: June 7-11 (8:00 AM – 5:00 PM) \$120.00 ____

Camp #2: June 28- July 2 (7:30 AM – 12:30 PM) \$75.00 ____ Both Camps ____\$175.00

CAMPERS NAME _____ GENDER ____ AGE ____ GRADE NEXT YR. ____

PARENT(S) / GUARDIAN(S) NAME(S) _____

ADDRESS _____

HOME # _____ WORK # _____ CELL # _____

E-MAIL _____ (For Up-Dates and Camp News, Photos and Records)

MEDICAL INSURANCE FORM

I, the undersigned, have been informed and agree, that all medical expenses resulting from illness or injury incurred as a participant in this "Missing Link" Basketball Camp, are the responsibility of the participants family. I will not hold Athens Christian School, Coach Link, or his staff responsible.

____ My son/daughter is covered by medical insurance.

The company name is _____ Group # _____ or, Policy # _____

____ My son/daughter is not covered by medical insurance. I, understand, I, the undersigned, will assume total responsibility for any medical expense that he/she may incur, before, during, or after, this "Missing Link" Basketball Camp.

MEDICAL RELEASE

I, the undersigned, have been informed and agree, that during the "Missing Link" Basketball Camp, first aid will be administered if necessary by the staff until medical care facilities can be reached. I will be informed of medical treatment that my son/daughter has received.

I, the undersigned, agree to the arrangements set forth above and hereby consent to the delivery of routine medical care and first aid to my child, as described above, without need of any additional consent from me.

I understand that in case of a major medical emergency, every possible attempt will be made to contact me before treatment is administered. However, the Camp Director may consent on my behalf to treatment advised by medical personnel for my son/daughter in the event I cannot be contacted through reasonable efforts.

Signed _____ Relationship _____ Date _____