

Iowa State University



Cyclone Basketball Travel Camp Alta High School June 25, 2009

Featuring: Iowa State Cyclone Coaching Staff
Iowa State Cyclone Players as Camp Counselors

One Day Camp Schedule for Boys & Girls K-9

Check In:	12:30 – 1:00 p.m.
Camp Instruction:	1:00 – 4:00 p.m.
Autograph & Photo Session:	4:00 – 4:30 p.m.

Camp Features

Iowa State Cyclone Basketball T-Shirt
Iowa State Cyclone Basketball
Individual Player Development Booklet
Contest Awards
Autograph and Photo Session

Camp Cost

\$35

Enroll at: www.cyclonebasketball.com or Telephone (515) 294-9342 or Mail

Make checks payable to: Cyclone Basketball Camps
383 Hilton Coliseum
Ames, IA 50011

The Cyclone Basketball Camps are a property of G Mac Hoops LLC

Cyclone Basketball Camp Registration

This camp is open to any and all entrants meeting the following requirements: male & female, grade K-9, first 100 registered.

Name _____ Grade (Fall 2009) _____

Address _____ Age _____ Boy _____ Girl _____

City/State _____ Zip _____ Telephone _____

School _____ E-Mail _____

Cyclone Basketball Travel Camp Site _____

Camp Fees and Refund

Your registration will not be processed without full payment. Refunds will only be given when we receive a notice from a doctor stating that the athlete is physically unable to participate in the camp. If this occurs a \$10 administrative fee will be deducted from your refund.

Release and Medical Authorization

The release and the treatment authorization must be signed by a parent or guardian if student is under 18 years old. Students who are 18 years old or will become 18 years old before the end of the camp/clinic must also sign. In order for students to participate in camp activities, we must have this form prior to the camp's start date. Otherwise, parent or guardian must be contacted prior to release to participate.

PHYSICIAN'S AUTHORIZATION

This is to certify that this individual was examined by me on _____ (valid if within one year of camp) and that I found this individual to be physically able to participate in vigorous physical and competitive athletic sports. (School physical form is acceptable if valid within one year of the starting date of camp.)

Date of Physical Exam _____ Allergies / Drug Sensitivities _____

Other medical problems / current medications _____

Is an identification band or card carried to alert others to the allergy(ies), medical conditions or medication use? Yes ___ No ___

Signed (Physician) _____ Date _____

Address _____ Office Phone _____

RELEASE OF LIABILITY, MEDICAL AND SURGICAL AUTHORIZATION

In consideration of the Cyclone Boys Basketball Camps/Clinics of Iowa State University granting the student permission to participate in Cyclone Boys Basketball Camps/Clinics, I hereby assume all risks of his or her personal injury (including death) that may result from any Cyclone Boys Basketball Camp/Clinic activity. As guardian, I do hereby release the State of Iowa, Iowa State Board of Regents, Iowa State University, Cyclone Boys Basketball Camps/Clinics, G.Mac Hoops LLC and their officers, employees, agents, all instructors, and all participants in said Cyclone Boys Basketball Camps/Clinics from all liability, including claims and suits at law or in equity, for injury, fatal, or otherwise which may result from the student taking part in Cyclone Boys Basketball Camp/Clinic Activities.

In addition, I hereby authorize and give my consent to the health authorities of Iowa State University or any licensed health professional to perform upon or administer any reasonable, necessary surgical or medical treatment. I also give permission to administer whatever anesthetic may be necessary or advisable during the medical or surgical procedures. This authorization is intended to cover emergency treatment, immunizations, injections, and minor operations and procedures. In the case of psychiatric and/or psychological treatment, parent authorization for treatment beyond that responsive to the emergency will be requested. I agree to assume all costs related to such treatment. I authorize my insurance company to pay benefits of Iowa State University Health Service or other hospitals and clinics.

Parent's / Guardian's Signature _____ Date _____

Student's Signature _____ Date _____

Also, I authorize the disclosure of medical information to my insurance company for the purpose of claim. I understand that I will be responsible for any medical or other charges in connection with student's attendance at this camp. (Each camper must provide his/her own medical insurance.)

INSURANCE INFORMATION (please print)

Name _____ Insurance Company _____

Insurance Company Address _____

Policy Number _____ Policy Holder _____

Does your insurance carrier require prior approval? Yes ___ No ___