



Inner City Tennis Project

Fall Participant Application & Medical Emergency Authorization Form

Please advise that there will be a \$20 nonrefundable application fee, free lessons applicants are exempt from the application fee

Applicant Personal Information

Full Name: _____ Race: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone Number: _____ Email: _____

Sex: _____ Date of Birth: ____/____/____

School affiliation: _____ Grade /Classification: _____

Parent Name: _____

Local Alternative(s) to be reached if the above parent cannot be reached

1st Alternative Name: _____ Phone Number: _____

2nd Alternative Name: _____ Phone Number: _____

Consent

PART I: Consent

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while While Involved the Inner city Tennis Project activities, when parents or guardians cannot be reached.

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical specialist: _____ Phone _____

Local Hospital _____ Emergency Room Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

PART II - REFUSAL TO CONSENT I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the Inner City Tennis Project authorities to take the following action (written instructions must be completed):

Signature of Parent/Guardian _____ Date ____ / ____ / ____

Medical History

Has your child had a health exam in the last year? Yes _____ / No _____

Is your child able to participate in an active program? Yes _____ / No _____

Has your child received a covid 19 vaccine? Yes _____ / No _____

Was the vaccine process completed? Yes _____ / No _____

Are there any medical concerns that the Inner-City Tennis Project staff should be aware of?

Yes _____ / No _____

If Yes Please indicate here in detail:

Does your child require medication? Yes _____ / No _____

If Yes Please indicate here in detail the medicine and when it should be taken or applied. _____

Please List any other issues concerning your child/children that we should be aware of:

Please Select which session you plan to attend:

- (Monday, Wednesday, Friday) 4:00PM – 5:30PM (Beginners + intermediate)
- (Monday, Wednesday, Friday) 5:30PM – 7:00PM (Advanced)
- (Tuesday, Thursday) 4:00PM – 5:30PM (Beginners + intermediate)
- (Tuesday, Thursday) 5:30PM – 7:00PM (Advanced)
- (5 days a week Monday- Friday) 4:00PM – 5:30PM (Beginners + intermediate)
- (5 days a week Monday- Friday) 5:30PM – 7:00PM (Advanced)
- FREE Sessions (Saturdays) 3:00PM – 5:30PM (Free Sessions to all Levels)

*****PHOTOGRAPHS*****

Children are frequently photographed in activities which are then used on our web site or publicity. They are NOT identified in photos without your permission; nor are their photos sold or used in any unauthorized way.

Travel Consent:

_____ *my child has my permission to travel to tennis related activities with the Inner-City Tennis Project.*

Signature: _____

Date: ___/___/___
