

Basic Information	
Campers Name:	<input type="text"/>
Date Of Birth:	<input type="text"/>
Address:	<input type="text"/>
City:	<input type="text"/>
State:	<input type="text"/>
Zip:	<input type="text"/>
Parent Or Guardian:	<input type="text"/>
School:	<input type="text"/>
Grade:	<input type="text"/>
Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Home Telephone:	<input type="text"/>
Email Address:	<input type="text"/>
Health Insurance Information	
Health Insurance Carrier:	<input type="text"/>
Policy Number:	<input type="text"/>
Emergency Contacts	
Emergency Contact 1:	<input type="text"/>
Relationship:	<input type="text"/>
Phone Number:	<input type="text"/>
Cell Number:	<input type="text"/>
Emergency Contact 2:	<input type="text"/>
Relationship:	<input type="text"/>
Phone Number:	<input type="text"/>
Cell Number:	<input type="text"/>
2010 Sessions	
Weekend Bootcamp	<input type="checkbox"/> March 8th, 2010 until April 26th, 2010
Summer Kickoff	<input type="checkbox"/> June 21- June 25
Week 1	<input type="checkbox"/> June 28- July 2
Week 2	<input type="checkbox"/> July 12-July 16
Week 3	<input type="checkbox"/> July 19-July 23
Week 4	<input type="checkbox"/> July 26-July 30
Week 5	<input type="checkbox"/> Aug 2-Aug 6
Week 6	<input type="checkbox"/> Summer-End Skillz Camp Aug 16-Aug 20
Nardi and Boyle Skills Academy	<input type="checkbox"/> Aug 2-Aug 5
By checking the accept box below, I submit that my child is physically fit to participate in	

strenuous athletic activity, and waive KBBC of any and all responsibility for injury or illness. I hereby release the directors of KBBC of any and all responsibility for injury or illness. I hereby authorize the directors of KBBC to act for me accordingly to their best judgement in an emergency requiring medical attention. I understand that I am solely responsible for the payment of said medical expenses and must provide the camp with proof of medical/accident insurance. I understand the procedure regarding the non-refundable deposit, and refund policy. I understand a credit card will only be given for documented medical emergencies. There is a \$30 charge for returned checks.

I Accept The Terms Above

Parent or Guardian Signature _____

Date: _____

Mail To: KBBC
502 Albermarle St.
Rahway, NJ 07065