



### 2010-2011 Player Registration Form

Our mission is to be the premier basketball academy in the country providing the highest quality coaching to committed athletes. We provide a structured training environment at a world class facility geared to develop team success as well as individual player growth. We strive to achieve maximum potential to create opportunities for our player beyond travel team basketball.

**Camp Session:** Session 1: June 28 - July 2 \_\_\_\_\_ Session 2: August 2-6 \_\_\_\_\_  
Session 3: August 9 - 13 \_\_\_\_\_ Session 4: August 16-20 \_\_\_\_\_

**Full Day Camp \$249 Half Day Camp \$149**

Mail payment to:  
**HAX**  
3203 Jack Northrop Ave  
Hawthorne, Ca 90250  
310-219-0600

#### Player Information:

Player Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Division: \_\_\_\_\_ Position: \_\_\_\_\_ T-Shirt Size: \_\_\_\_\_

Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

Any health problems or allergies we should know about: \_\_\_\_\_

Basketball Experience ( in years): \_\_\_\_\_ Travel Team \_\_\_\_\_ Rec League \_\_\_\_\_

#### Parent Information:

Parent/Guardian(s)Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

#### HAX Information and Release

I hereby give my permission for the above player to participate at HAX in the tryout/ basketball program. I understand that as a condition of admittance as a participant, I the undersigned, release HAX, Its officials and members from any liability for any injury or illness, mental or physical, due to the players participation during or related to HAX. In the event of any accident or injury, I (we) the undersigned parent(s)/Guardian(s) give my/(our) consent for emergency medical care prescribed by a duly licensed doctor of Medicine and/or Doctor of Dentistry. I hereby grant authority to a qualified physician or dentist to render such medical treatment as said physician and/or dentist deems necessary under the circumstances and to preserve the life, limb or well being of my dependent.

Parent Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Guardian/Name (print): \_\_\_\_\_