HOOPS Life™
Membership Form

Child's Name:_____ DOB:_____

Grade:_____ School:_____

Height:_____ Weight:_____ Gender: M F Lives with: Both Parents *or* _____

Physician:_____Phone:_____

Insurance:_____Phone:_____

Mother's Name:_____

Address:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____

Martial Status: Single Married (if Married) Spouse's Name:_____

Father's Name:_____

Address (if different):_____

Home Phone:_____ Cell Phone:_____ Work:_____

Email Address:_____

Martial Status: Single Married (if Married) Spouse's Name:_____

Alternate Emergency Contact & Permission to pick up child other than Mother or Father

Name:_____ Cell Phone:_____
Relationship to child:_____

Name:_____ Cell Phone:_____
Relationship to child:_____

Please list any important medical information that would be important for us to know.