TRI-COUNTY YOUTH BASKETBALL ASSOCIATION

PARENTAL CONSENT/RELEASE - MEDICAL TREATMENT AUTHORIZATION

In consideration of your acceptance of this entry, I / We, intending to be legally bound, do hereby, for myself, my child, ward, heirs, executors, and administrators, do waive, release and forever discharge, any and all rights and claims for damages which I / We may have, or which may accrue to me / us against Tri-County Youth Basketball Association, directors, facilitator, coaches, officials, schools, competing teams or any other support staff, groups or organizations, their respective officers, agents, sponsors, and / or representatives for any and all damages which may be sustained and/or suffered by my child, or ward in connection with their participation, or may arise out of traveling to or participating in, and returning from Tri-County Youth Basketball Association event(s), or sponsored activities.

I hereby consent and give my permission for my child/ward _____
to participate in Tri-County Youth Basketball Association Programs, and grant authority to the coaches to act as guardian, or spokesman in granting permission fur emergency treatment or hospitalization (including anesthesia) If necessary for my child/ward, while traveling to or from, or at the site of Tri-County Youth Basketball Association events. I understand that should an emergency arise, I will be notified, but that if I cannot be reached by telephone, such medical treatment as deemed necessary by competent medical personnel is authorized. I / We do hereby agree to be financially responsible for the payment of all charges, billings, and accounts which are the result of said treatment.

By witness of my signature below, I / We verify that I / We have read, and understand, and intend to be legally bound by the terms stated above.

_____ _____
Signature of Player Date Signature of Guardian Date

_____ _____
Printed Name of Player Father or Guardian's Printed Name

_____ _____
Home Phone Number Signature of Mother or Guardian Date

_____ _____
Father's Work Number Mother or Guardian's Printed Name

_____ _____
Mother's Work Number Preferred Hospital (please print)

_____ _____
Other Emergency Contact (please print) Phone Number

_____ _____
Family Physician (please print) Phone Number

_____ _____
Insurance Policy, Provider (please print) Policy, or Group Number

List any other medical conditions, allergies, needs, allergies to medication, or pertinent information.

_____

_____

_____