

Basketball Program

(PRINT ALL INFORMATION)

Participant Name: _____ Age: _____

Parent Name (If under 18): (1) _____

(2) _____

Cell Phone #: (_____) _____ - _____

Email Address: _____

If Parent / Guardian **CAN NOT** be reached by the above cell phone number who do you want us to contact in case of an emergency.

Name: _____ Relationship to Participant: _____

Cell Phone #: (_____) _____ - _____

By enrolling the **ABOVE** player, I ensure that such individual is physically and mentally able to participate in **ALL** camp / league activities and has been examined by a licensed medical physician within one (1) year prior to attending camp / league activities.

I **UNDERSTAND** that the **TOWN OF OAK BLUFFS**, it's Directors, Officers, Employees, Representatives, Independent Contractors, **CAN NOT** be held responsible in whole or part for **ANY** accidents, illness of injuries resulting in medical or dental expenses incurred from participation in this program.

I hereby **RELEASE** each of them from and against **ANY** and **ALL** claims, cost liabilities and injuries incurred while playing in the camp / league. I **AGREE** to **ASSUME** full and complete responsibility for any and all medical bills arising from a player's participation.

In the event of ANY emergency, I authorize the OAK BLUFFS PARK & RECREATION DEPARTMENT to exercise its judgement in the treatment of said player by a medical authority.

By signing this release and agreement form, I acknowledge that I HAVE READ AND FULLY UNDERSTAND AND AGREE TO ALL OF ITS TERMS.

I execute this waiver voluntarily and with full knowledge of its significance to be binding on my heirs, my executors, administrators, assigns and myself. I accept the terms stated above.

Signature (Of Parent / Guardian if under 18): _____

Date: _____

(Below filled in by Niantic Park Basketball Program Staff – ONLY)

Please fill in the appropriate time that the above WILL be participating in the Niantic Park Basketball Camp / League.

_____ Days

N/A - Sessions

N/A - Summer

Amount Due _____

Amount Paid _____

How Paid _____

Person who took the payment MUST initial this sheet: _____

Medical Page

Participant: _____

Please list ANY MEDICAL HISTORY that the staff of the Niantic Park Basketball Program needs to be aware of.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list MEDICAL TREATMENT that YOU (Parent/ Guardian) would like the staff of the Niantic Park Basketball Program to FOLLOW in the case of an episode.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

In the event of a MEDICAL episode, the staff of the Niantic Park Basketball Program WILL notify the appropriate authority if said episode is beyond their scope of medical training.