~Issac Gildea ~

Next Generation Basketball & weight training

Registration, Liability and Medical Release Form

Players Name:	
Birthdate:	
Mailing Address:	
Phone:	
Parent/Guardian: Email:	
EmergencyContact: other than Parent	Name: Phone:

I, the Parent of the above named participant in the Humboldt Wild AAU Basketball Issac Gildea Next Generation Basketball & Weight Training, hereby give my approval for my child to participate in any Humboldt Wild AAU Basketball Issac Gildea Next Generation Basketball & Weight activities, including transporting to and from the activities. I know that the participation in basketball & Weight Training may result in serious injuries to players, and do hereby waive, release, absolve, indemnify and agree to hold harmless The Humboldt Wild AAU incorporated, Issac Gildea, the organizers, sponsors supervisors, participants and persons transporting my child to and from activities from any claim arising out of injury to my child whether the result of negligence or for any other cause, except to the extent of the amount covered by accident or liability insurance.

Participation in the AAU Basketball Issac Gildea Next Generation Basketball & Weight Training requires the ability to run, throw, catch and jump as well as lift weights Additionally, requires the capacity to understand the rules of the game and the weight room.

Parent/Guardian
Signature:____Date:____

Medical and Parent Treatment Authorization:

Please indicate any physical limitations: (allergies, hearing, sight, etc)____
Hospital Choice:____ Family Insurance Carrier:______________________
Physician Phone Number:____

I hereby give my consent and authorization for_______________________ (child Name) in the event of injury or illness, to be medically treated by a qualified physician allow such physician to render such medical treatment as the doctor deems necessary under the circumstances including, but not limited to, first aid treatments, anaesthesis, suture of wounds, x-rays and/or hospitalization.

Parent/Guardian Signature_______________________________________Date:______________________________________

If, on the grounds of your beliefs, you DO NOT WISH that your child be taken to a doctor, hospital or clinic, nor be treated by a doctor, hospital, or clinic please sign here:

Parent/Guardian Signature_______________________________________Date:____________________________________