Basketball Beginnings INHouse Registration Form

Date_____

Program ____Eight-week Skills Program_____

Name of School/Institution_____Cost_____

Participant Information

First Name_____ Last Name_____ Male / Female

Birth Date _____ Age at time of session_____

Address_____ Suite_____

City_____ Prov_____ Postal Code_____

Parent/Guardian_____

Home#_____

Business#_____

E-mail_____

Have you attended one of our programs in the past? **Y** ☐ **N** ☐

_____
Parent/Guardian Signature

INFORMED CONSENT AGREEMENT

I/WE the undersigned, hereby acknowledge that certain **RISKS** or **INJURY** are inherent to participation in sports and recreational activities. Types of injuries may be minor or serious and may result from one's own actions, the actions of others, or a combination of both.

I/WE hereby **WARRANT** being physically fit to participate and understand that the **CHOICE** to participate brings with it the **ASSUMPTION OF THOSE RISKS AND RESULTS**, which are part of these activities.

I/WE agree that **Basketball Beginnings** or its employees, servants or agents shall not be liable for any injury to my person or loss or damage to my personal properties arising from, or any way resulting from, my participation in these activities, UNLESS such injury, loss or damage is caused by **SOLE NEGLIGENCE** of **BASKETBALL BEGINNINGS** or its employees, servants or agents while acting within the scope of their duties. I/WE declare having read and understood the above **INFORMED CONSENT AGREEMENT** in its entirety and my signature indicates my consent to participate acknowledging all of the foregoing.

_____
Participants Name (please print)

_____
Participant's Signature

_____ _____
Parent/Guardian's Name (please print) Print Witness Name

_____ _____
Parent/Guardian's Signature Witness Signature

Personal Health and Medical History

(**Standard form to be filled out annually by all participants)**

This record is required annually for all participants. It includes any event that does not exceed seventy-two consecutive hours, where the level of activity is similar to that normally expended at home or at school, and where medical care is readily available. Medical information required, is a current health history signed by parents or guardian. This form is filled out by participants and kept on file for easy reference.

PERSONAL INFORMATION

Name_____Date of Birth_____ Age____ M◯ F◯

Name of Parent or Guardian _____ Telephone _____

If the person above is not available in the event of an emergency, notify

Name _____ Relationship_____Telephone _____

Name of personal physician _____ Telephone _____
Participants Health #_____

Check items that apply, past or present, to your health history. Explain any "Yes" answers

ALERGIES: Food, medicines, insects, plants: Yes ( ) No ( )

If yes explain: _____

GENERAL INFORMATION

	Yes/No		Yes/No		Yes/No
Asthma	( ) ( )	Diabetes	( ) ( )	High blood pressure	( ) ( )
Cancer/leukemia	( ) ( )	Heart Trouble	( ) ( )	Kidney disease	( ) ( )
Convulsions/seizures	( ) ( )	Hemophilia	( ) ( )		

If yes for any please explain _____

List any medications taken _____

List any physical or behavioral conditions that affect or limit full participation_____

_____

List any equipment needed such as wheelchair, contacts, etc.: _____

IMMUNIZATIONS: (give date of last inoculation or booster if you can) _____

Date_____ Signature of parent/guardian _____