APPLICATION
Mogadore Youth Basketball Association

NAME	AGE	GRADE
ADDRESS	PHONE	
CITY	BIRTHDATE	

T-SHIRT SIZE (Circle One)			
Youth Small	Youth Medium	Youth Large	Youth XLarge
Adult Small	Adult Medium	Adult Large	Adult XLarge

Short Size _____ (for 3rd grade – 6th grade)

I/We the parent/guardian of the above named child, who is a candidate for a position on a Mogadore Youth Basketball Team hereby give my/our approval to his/her participation in any and all of the association's activities during the current season. I/We assume all risks and hazards incidental to the conduct of the activities. I/We further release and absolve the organizers, sponsors, and supervisors, and any or all of them, in case of injury to my/our child. I/We hereby waive all claims against the organizers, sponsors, or any of the supervisors appointed by them.

I/We understand that my/our child is required to participate in all fund raising activities benefiting the Mogadore Youth Basketball Association.

I/We further accept responsibility for all uniform pieces or equipment that my child receives. I/We agree to replace, via payment, any uniform piece that is lost, stolen, or damaged outside of normal usage.

_____ _____

Signature of Parent/Guardian Date

MONEY IS <u>NOT REFUNDABLE</u> SHOULD A PLAYER DECIDE THAT HE/SHE NO LONGER WANTS TO BE INVOLVED IN THE MOGADORE YOUTH BASKETBALL ASSOCIATION.

Please do not complete will be completed by Assocation.

Payment Amount		Cash		Check #	
Grade		Team		Coach	

Mogadore Youth Basketball Assocation

NAME	HOME PHONE	ADDRESS

To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under Mogadore Youth Basketball Association supervision, when parent or guardian cannot be contacted.

SECTION 1 or 2 MUST BE COMPLETED

SECTION 1 – GRANT CONSENT

In the event reasonable attempts to contact the following have been unsuccessful

PARENT/GUARDIAN	PHONE 1	PHONE 2	ADDRESS
1.			
2.			
NEAREST RELATIVE	PHONE 1	PHONE 2	ADDRESS

I hereby give my consent for the administration of any treatment deemed necessary by:

FAMILY PHYSICIAN	PHONE	ADDRESS
FAMILY DENTIST	PHONE	ADDRESS

In the event the designated preferred physician and/or dentist is not available, I hereby give consent for treatment by any licensed dentist.

I hereby give my consent to allow my child to be transferred by emergency medical services to _____ hospital reasonably assessable. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or licensed dentists, concurring in the necessity for such surgery are obtained before surgery is performed. Facts concerning the child's medical history, including allergies, medications being taken and any physical impairments to which a physician and/or dentist should be alerted to as follows:

ALLERIGIES (IF ANY)
MEDICATIONS (IF ANY)
PHYSICAL IMPAIRMENTS (IF ANY)

PARENT/GUARDIAN SIGNATURE	DATE	ADDRESS

DO NOT COMPLETE SECTION2 IF YOU COMPLETED SECTION 1

SECTION 2 – DO NOT GRANT CONSENT

I do not give consent for emergency medical treatment of my child. In the event of illness or required emergency treatment, I wish the authorities to take no action or to:

PARENT/GUARIDAN SIGNATURE	DATE	ADDRESS