KELOWNA MINOR BASKETBALL ASSOCIATION

MEDICAL WAIVER

Name Of Participant: _____

Gender: M F Date Of Birth: _____

Care Card #: _____

Name Of Parent / Guardian: _____

Parent / Guardian Phone #: _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____

Please Indicate Any Current Medical Condition: _____

Please Indicate All Prescriptions That You Are Taking: _____

Consent To Emergency Medical Treatment & Release Of Medical Records

1. I hereby consent to and authorize emergency medical and/or dental treatment my son/daughter's involvement in any programs offered under Kelowna Minor Basketball Association or Leagues.
2. I hereby consent to the release of medical information to the KMBA in any event of injury or other medical emergency.
3. I hereby acknowledge that no treatment or procedure referred to above will be administered to except with the consent by myself or appropriate substitute decision maker in accordance with appropriate legislation and with the same limitation and conditions contained therein.
4. I hereby confirm that this in not a power of attorney for personal care.

Parent / Guardian Signature: _____

Date: _____