Parent/Guardian Waiver, Release of Liability and Indemnification Agreement

I, the undersigned parent or guardian of ________________________ (the minor or guardian), acknowledge, agree and understand that:

1. The above named minor/guardian is in good health and proper physical condition to participate in DSACO's 2018 Summer Basketball Camp on (check all that apply) ☐ June 22-23 (Youth session) ☐ June 22-23 (Adult session) ☐ July 20-21 (Youth session) ☐ July 20-21 (Adult session)

2. There are certain risks and hazards involved in the above named minor/guardian participating in the camp that may result in injury or death to the minor/guardian or other players including, but not limited to those hazards associated with playing conditions, equipment, and other participants.

3. I hereby release, discharge and agree not to hold liable the Down Syndrome Association of Central Oklahoma, or its Board, executives, officers, employees, volunteers, sponsors or any person or entity connected with the 2018 DSACO Basketball Camp including other participants for any claim, damages, costs or cause of action which the minor/guardian or I have or may in the future have as a result of injuries or damages sustained or incurred by the above named minor/guardian from whatever cause including but not limited to the negligence, breach of contract or wrongful conduct of the parties hereby released.

I ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND EACH AND EVERY ONE OF THE PROVISIONS IN THIS WAIVER, RELEASE OF LIABILITY AND INDEMNIFICATION AGREEMENT AND AGREE TO ABIDE BY THEM.

Name of Parent or Guardian____ Phone___________________________

Address____

Signature of Parent or Guardian____ Date_________

EMERGENCY CONTACT NAME____ **PHONE**_________________________

Camp Health Exam/Record (to be signed by physician)

I certify that___________________________________:

_____ May participate in basketball camp

_____ May participate except for:____

Medical information pertinent to routine care and emergencies:____

____

Comments____

____

Physician Name____ Phone___________________________

Physician Signature____Date___________________________