PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

CYO BASKETBALL

Participant's name: ____
Birth date: ____________________________________ Sex: __________
Parent/Guardian's name: ____
Home address: ____
Home phone______________Cell_________________Business______________

I, ________________________ grant permission for this participant,____________
Parent or guardian's name
to participate in this location's CYO basketball team. This activity will take place under the guidance and direction of parish/school employees and/or volunteers from ____________________________.
Name of parish/school

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above-named participant.

I agree on behalf of myself, this participant named herein, or our heirs, successors, and assigns, to hold harmless and defend ______________________________, the
Name of parish/school
Roman Catholic Bishop of Fall River, Corp Sole, its officers, directors, employees and agents, volunteers, or representatives associated with CYO basketball, from any claim arising from participating in CYO basketball or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the parish/school, the Roman Catholic Bishop of Fall River, Corp Sole, its officers, directors, employees and agents, volunteers, or representatives associated with the CYO basketball team and league for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish/school.

Print Name: ____

Signature: ______________________________________ Date: ____________

COMPLETE REVERSE SIDE IN FULL

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, this participant is in good health, and I assume all responsibility for the health of this participant.

Medical Treatment: In the event that this participant becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be contacted at the following phone numbers:
1_____________________ 2_______________________ 3 _______________________

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport this participant to a hospital for emergency medical or surgical treatment. I wish to be advised by the hospital or doctor prior to any further treatment. In the event of an emergency, if you are unable to reach me at the provided numbers, contact:

Name & Relationship: __________________________________ Phone________________
Family Doctor: _______________________________________ Phone: _______________
Family Health Plan Carrier: _____________________________ Policy #: ______________

Signature: ____ Date: _____________

Medications: This participant is taking medication at present. The parent/guardian will ensure medications are well-labeled and will bring such medications and present them to the parish/school. Names of medications and concise directions including dosage and frequency of dosage, are as follows

Signature: ____Date: _____________

Non-Prescription medication: of any type, (i.e. non-aspirin products such as ibuprofen or acetaminophen, throat lozenges, cough syrup):
CHOOSE ONE: ☐ **may** ☐ **may not** be administered to this participant
☐ contact me at the #'s provided before administering

Signature: ____Date: _____________

Specific Medical Information: The parish/school will take reasonable care to see that the following information will be held in confidence.
Allergic reactions (medications, foods, plants, insects, etc.): _________________________
Date of last tetanus/diphtheria immunization ______________________________________
Does this participant have a medically prescribed diet?______________________________
Any physical limitations? ____

Is this participant subject to emotional reactions to new situations, anxiety?
____

Has this participant recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? If so, list date and disease or condition:
____

You should be aware of these special medical conditions of this participant:

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