



# Classics Basketball

Liability Waiver and Consent for Medical Treatment  
(Return to your Coach/Team Manager)



Player Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_  
(City) (State) (Zip)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent Name(s): \_\_\_\_\_  
(Father) (Mother)

Cell/Emergency Phone: \_\_\_\_\_  
(Father) (Mother)

Health Insurance Provider: \_\_\_\_\_ Phone#: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Health Conditions/Medications/Allergies: \_\_\_\_\_

**Liability Waiver:** Basketball presents certain inherent risks and hazards, which the Player-participant and parent/guardian are urged to consider and which the Player assumes. To the best of my knowledge, there are no physical or other health-related conditions, which will interfere with my child's participation unless noted above. I, the undersigned parent/guardian for the above named Player, understand and acknowledge that such recreational activities have inherent risks, dangers and hazards, foreseeable and unforeseeable, that may result in injury, illness, or property damage, and on behalf of myself, my family, agents and contractors, I hereby release and agree to hold harmless Classics Basketball, Inc., its sponsors and its AAU registered volunteer coaches, managers, club officers and directors, from all claims, actions, or losses related thereto. Classics Basketball, Inc., assumes no liability for injury or damage arising from the results of participation of the above Player unless due to willful fault or gross negligence on the part of Classics Basketball, Inc. I also agree that my child will be a registered AAU member with Added Benefit Insurance coverage.

**Medical Treatment Release:** Due to the strenuous nature of basketball, the Player participant is urged to consult her physician concerning her fitness to participate. I, the undersigned parent/guardian for the above named Player hereby approve of my child's participation in the Classics Basketball program and consent to emergency medical treatment for my child on my behalf. I also authorize any AAU-registered adult of Classics Basketball to obtain any necessary medical treatment for my child on my behalf, in case of an emergency, where I am not present and with the understanding that I will be notified as soon as possible. My health insurance information has been provided above.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coach or Team Manager will have a copy of this form at all practices and games.