



# 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 during 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 is not a power of attorney for personal care.

Parent/Guardian Signature \_\_\_\_\_

Date: \_\_\_\_\_