KNIGHT HOOPS

2023-2024 CONSENT FOR MEDICAL TREATMENT AND RELEASE AND HOLD HARMLESS AGREEMENT

PLAYER NAME: _____ DOB: _____

ADDRESS: _____

HOME PHONE: _____ GRADE: _____

PARENT'S EMAIL: _____

FATHER NAME: _____ CELL: _____

MOTHER NAME: _____ CELL: _____

EMERGENCY CONTACT: _____ PHONE: _____

In the event of any medical emergency involving the PLAYER, the undersigned, as his/her parent or guardian, hereby grants authority and consent to the staff of Knight Hoops, King's Schools ("KING'S"), or CRISTA Ministries ("CRISTA") supervising the above activity to administer or arrange for reasonable medical care for the PLAYER in the event that I cannot be contacted in time by reasonable means. For the medical emergency I further consent and grant authority to a physician, nurse or other appropriate health care provider to render whatever emergency care they deem necessary.

I hereby release Knight Hoops, KING'S and CRISTA, their employees, directors and agents from any liability, and agree to hold them harmless for any expense (medical, ambulance, etc.) arising out of their reasonable efforts to provide such emergency medical care for the PLAYER.

I further agree to take sole financial responsibility for any medical services rendered to the PLAYER which are not provided for through school insurance and hereby grant to the employees, directors and agents of Knight Hoops, KING'S or CRISTA a special power of attorney to arrange such reasonable medical services.

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I also understand the risks inherent in participating in basketball, and, by my signature, agree to indemnify and release the employees, directors and agents of Knight Hoops, KING'S and CRISTA from all liability, claims and causes of action arising out of PLAYER's participation in the Knight Hoops programs or which may arise while traveling to or returning from related events

_____ _____

Signature(s) of Parent/Guardian **Date**

_____ _____

Signature(s) of Parent/Guardian **Date**

Group/Policy #: _____ Hospital Preference: _____

Physician's Name: _____ Physician Phone: _____

Medical Insurance Provider: _____ Policy Holder Name: _____

Pre-existing Conditions, allergies or other information we should know in case of emergency (continue on back of form if more space is needed):