Basketball Club of WNC

PO Box 8666 Asheville, NC 28814 828-251-5107

MEDICAL RELEASE FORM

I, the undersigned, have been informed and agree that all the medical expenses resulting from illnesses or injury involving (Participant's Name)_____in the Basketball Club of WNC are the responsibility of the participant's family.

Please place your initials on the appropriate line below:

_____ My child is covered by medical insurance.

Insurance Company Name: _____

Group Number: _____ Policy Number: _____

_____ My child is not covered by medical insurance. I, the undersigned, will assume responsibility for any medical expenses he/she incurs during participation in the club.

I, the undersigned, have been informed and agree that during any club activity first-aid will be administered if necessary by the staff until medical care facilities can be reached. I will be informed of any medical treatment my child has received.

I, the undersigned, agree to the arrangement set forth above and hereby consent to the delivery of routine medical care and first-aid to my child as described above, without need of any additional consent form from me. I understand that in case of a major medical emergency every reasonable attempt will be made to contact me before treatment is administered. However, a camp leader may consent on my behalf to treatment advised by medical personnel for my child in the event I cannot be contacted through reasonable efforts.

Parent Signature_____Date_____

Parent Signature_____Date_____

Medical History:	**Please explain any questions answered Yes.**		
	Allergy (Foods, Medicines, etc.)	Yes	No
	Existing Injury Under Treatment	Yes	No
	Medical Conditions Under Treatment	Yes	No
	Birth Deformities	Yes	No
	Fractures Or Disability Type Injuries	Yes	No
	Mental Disorders Or Convulsions	Yes	No
	Past Illnesses Of More Than One Week	Yes	No
	Contacts, Glasses, Hearing Aids, etc.	Yes	No