



# GIRLS BASKETBALL

M E R C E R I S L A N D

## MIHS Summer Hoop Camp

### MERCER ISLAND GIRLS BASKETBALL BOOSTER CLUB

#### MEDICAL AUTHORIZATION, RELEASE AND HOLD HARMLESS AGREEMENT FOR SUMMER HOOP CAMP

PLAYER NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ GRADE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT'S E-MAIL: \_\_\_\_\_

FATHER/  
GUARDIAN NAME: \_\_\_\_\_ CELL# \_\_\_\_\_

MOTHER/  
GUARDIAN NAME: \_\_\_\_\_ CELL# \_\_\_\_\_

EMERGENCY  
CONTACT: \_\_\_\_\_ PHONE# \_\_\_\_\_

#### RELEASE

In consideration of your acceptance of this release, I, intending to be bound, do hereby, for myself, the athlete, heirs, executors, and administrators, waive, release and forever discharge any and all rights and claims for damages which may have or which may here after accrue to the athlete against the Mercer Island Girl's Basketball Booster Club or the Mercer Island School District, or any other support group of organization, their respective officers, agents, representatives, successors, and/ or assigns for any and all damages which may be sustained and suffered by the athlete in connection with her association with or participation in any and all camps, practices, games, or tournaments involving her participation in camps or teams or which may arise out of traveling to or returning from said events.

I, or we, the parent(s) or guardian(s) of the athlete, grant to the directors, assistants, or assigned chaperones of the Islander Girls' Basketball Booster Club and the Mercer Island School District the right to act as guardian/spokesperson in granting permission for emergency treatment/hospitalization (including anesthesia) if necessary for my/our daughter while at above named activities. I understand that should a health emergency arise, I will be notified, but that if I cannot be reached by telephone, such medical treatment as deemed necessary by competent medical personnel is authorized.

\_\_\_\_\_  
SIGNATURE(S) OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

MEDICAL INSURANCE  
PROVIDER: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_ PHONE #: \_\_\_\_\_

HOSPITAL  
PREFERENCE: \_\_\_\_\_ KNOWN  
ALLERGIES: \_\_\_\_\_

MEDICINES UTILIZED: \_\_\_\_\_

PRE-EXISTING

HEALTH CONDITIONS:

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