



BAY AREA DISC ASSOCIATION

MEDICAL AUTHORIZATION FORM

The purpose of this form is to enable and authorize the provision of emergency treatment to minor children who become injured while attending a Bay Area Disc Association event under the authority of the **Bay Area Disc Association staff**.

This acknowledges that we, the undersigned, parent(s) or legal guardian(s) of

Name of participant Date of Birth

...recognize the potentially hazardous nature of the sport of Ultimate and understand that injury might be sustained as a result. These injuries include but are not limited to mild and serious injury, permanent disability, blindness, paralysis and death. I/We (the parent(s) or guardian(s)) of the child listed above, certify that to the best of my knowledge and belief, said child is in good health. In the event of such an injury to my child and I/we cannot be reached, I/we give the Bay Area Disc Association the authority to make all necessary arrangements for emergency care and give permission to qualified and licensed EMTs, physicians, paramedics and/or other medical or hospital personnel to render such treatment. I/we understand that we are entirely responsible for the costs of such treatment. Although some staff may be qualified in administering first aid, the camp does not employ fully trained medical personnel.

I/We release the Bay Area Disc Association as well as Community Initiatives, their employees, agents, volunteers and assigns from any personal injuries caused by or having any relation to this activity. We (I) understand that this release applies to any present or future injuries or illnesses and that it bind my heirs, executors and administrators.

This release form is completed and signed of my own free will and with full knowledge of its significance. I have read and understand all of its terms.

Parent/Guardian (required) Signature Date Phone

Parent/Guardian (2nd name is optional) Signature Date Phone

Family Physician Address Phone
(no signature is required)

Preferred Hospital:

Child's Medical Insurance Carrier:

Emergency Contact:

Specific medical conditions, health history, current medications, chronic illnesses or other conditions which a physician should be alerted to:

