

NORTHWEST YOUTH BASKETBALL ASSOCIATION

2009 Registration

Athlete's Name

Birth Date

Grade

Home Phone

Family Email Address

Fathers or Guardians Name

Cell Phone

Mothers or Guardians Name

Cell Phone

PLEASE CIRCLE YOUR DIVISION:

4th Grade Girls

5th Grade Girls

6th Grade Girls

7th Grade Girls

8th Grade Girls

4th Grade Boys

5th Grade Boys

6th Grade Boys

7th Grade Boys

8th Grade Boys

Team Name: _____

Coaches Name: _____

PARTICIPANTS' RELEASE AND WAIVER OF LIABILITY

I understand that acceptance of our child's entry in this basketball program is without responsibility of any kind by the NYBA and any other entities sponsoring or contributing to the program. I, on my child's behalf, do hereby for on behalf of ourselves and our heirs and legal representatives and our child RELEASE and forever discharge the NYBA, its officers and representatives, and any other entities or representatives of such entities sponsoring or contributing to the program from any and all claims, demands and injuries howsoever arising, whether caused by the negligence or intentional acts of the NYBA and its representatives and any other entities or representatives of such entities sponsoring or contributing to the program or by third parties, which injuries may be in any way related to my child's activities during the program and any period traveling to or from the program described and all such claims are hereby WAIVED AND RELEASED, and I on behalf of my child, covenant not to sue therefore.

THE PARENT (S) OR GUARDIAN (S) BY SIGNING DOES HEREBY AGREE TO INDEMNIFY AND HOLD HARMLESS THE NYBA AND ITS REPRESENTATIVES AND ANY OTHER ENTITIES SPONSORING OR CONTRIBUTING TO THE PROGRAM FROM ANY LIABILITY WHICH THEY MAY INCUR TO THE CHILD [PARTICIPANT], HOWSOEVER ARISING AND WHETHER CAUSED BY THE NEGLIGENT OR INTENTIONAL ACTS OF THE NYBA OR ANY OTHER ENTITIES SPONSORING OR CONTRIBUTING TO THE PROGRAM OR THIRD PARTIES.

Consent for Medical Treatment: As the parent/guardian of the above named player, I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Dentistry. This care may be given under whatever conditions are necessary to preserve life, limb, or well being of my dependent.

Parent/Guardian Signature

Date

COST: \$40 Per Athlete

OFFICE USE ONLY: Check/Cash _____ Check # _____ Date Paid _____