

ORONO BASKETBALL BOOSTERS

705 Old Crystal Bay Road
Long Lake, MN 55356
www.Oronobasketball.com

Presidents – Kelly Boyle and Travis Winkey

Community Education - Brian Bergstrom

RELEASE AND CONSENT

I (We) am aware that playing or practicing to play in any sport can be a dangerous activity involving many risks of injury. I understand that the dangers and risks of playing basketball include, but are not limited to serious injury to virtually all aspects of the skeletal/musculature system, internal organs, nervous system or brain and may result in injury or impairment of general health and well-being or even paralysis or death.

I further acknowledge that the sport of basketball is a hazardous activity and I (we) agree that neither the Orono Basketball Boosters coaches, directors, officers or other volunteers, nor Independent School District No. 278 or Orono Community Education department or staff shall be liable to me (us) for any injury or damage resulting from my (my child's) participation in the basketball program whether incurred on the court or otherwise.

In the event the participant identified below is injured or requires medical attention as a result of activities related to participation in the basketball program and reasonable attempts to contact me at the phone numbers indicated below have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by our family physician or health care provider indicated below or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the participant to the preferred treatment center of hospital identified below or any treatment center or hospital reasonably accessible.

Participant _____
(name) (signature) (date)

Parent or Guardian _____
(name) (relationship) (signature) (date)

Phone Number (home) _____ (work) _____ (work) _____
(cellular / pager) _____ (Other) _____

Physician or Health Care Provider: _____
(name)

Address _____ Phone _____

Dentist or Dental Provider: _____
(name)

Address _____ Phone _____

Preferred Treatment Center or Hospital _____
(name)

Address _____ Phone _____

Insurance Provider and policy number: _____

Special medical or treatment needs: _____
