



## Registration Form and Release

Child's Name: \_\_\_\_\_  
 Parents or Guardians: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 School: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Height: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Pre-requisite:** In order for a student to participate in Wahoops, Wahoops requires that they participate in WARA, middle school or another organized league/team at the most recently available opportunity. Please indicate the last league/team student was part of.

League/Team \_\_\_\_\_ Date \_\_\_\_\_  
 (e.g. WARA/Wahoo Middle School) (e.g. winter 09)

**PARENT'S RELEASE:**

I hereby give permission for my child to participate in the Wahoops program. I understand that the coaches and sponsors have no responsibility, assume none, and do not carry accident insurance for the benefit of my child.

I hereby, for myself, my spouse, if any, our heirs, and personal representative waive and release any and all claims for damages we may have against the coaches, sponsors, the driver of any motor vehicles transporting the children, their agents, representatives and assigns for injuries which my child might suffer while participating in this program.

I further agree that I will assume full responsibility for my child's medical expense and well being.

SIGNATURE OF PARENT OR GUARDIAN: \_\_\_\_\_

DATE: \_\_\_\_\_

**MEDICAL RELEASE: TO ALL HOSPITALS AND/OR MEDICAL PERSONNEL**

As parents or legally certified guardians of \_\_\_\_\_, a minor child, we do hereby give authority to the following coaches: \_\_\_\_\_

\_\_\_\_\_ to obtain all necessary medical assistance for my child, stated above, in the event of an emergency, including the assistance of a physician and/or hospital. This authorization is granted in situations wherein a parent cannot be reached immediately.

SIGNATURE OF PARENT OR GUARDIAN: \_\_\_\_\_

DATE: \_\_\_\_\_

**MEDICAL INFORMATION:**

Please check any of the following which may be applicable, (Describe if necessary)

Glasses: \_\_\_\_\_ Asthma: \_\_\_\_\_ Diabetes: \_\_\_\_\_ Epilepsy: \_\_\_\_\_

Allergies: \_\_\_\_\_ Hearing Loss: \_\_\_\_\_ Requires daily medication: \_\_\_\_\_

Orthopedic information: \_\_\_\_\_ Other: \_\_\_\_\_