C C Basketball
Medical Form

C C Basketball is a non-profit corporation. It is not sponsored by the town of New Providence and does not receive any public funds. All funds are raised by way of fees, fund-raisers, and donations. The funds are used primarily to buy equipment, purchase insurance, and pay tournament and referee fees. Registration fees are required by the C C Basketball to be paid in full at the time of sign-up registration. If the registration fees are not paid your child is ineligible to play.

I, the undersigned further certify that the undersigned child acknowledges the fact that physical hazards may be encountered, and waves all claims against the C C Basketball and its coaches for damages to themselves or other persons in their behalf for personal injuries that occur during participation in games and practices. I further understand and authorize the team trainer/head coach to provide necessary treatment to said child if they are injured and deemed necessary to have them treated (including medication) in a hospital until the arrival of the family physician and that my child has hospital and medical/surgical coverage.

_____ _____
Signature of Parent Date

_____ _____
Signature of C C Basketball Participant Date

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT FOR MINOR CHILD

I (we) undersigned state that I (we) am/are the (natural parent (s)) (Legal guardian (s)) having legal custody of

_____,
(Child's Name)

Who resides with me (us) and consent to x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state (s) of NEW JERSEY, NEW YORK, PENNSYLVANIA, MARYLAND (cross out any state you do not approve.) when needed for such treatment is immediate and when efforts to contact me (us) are unsuccessful.

Child's Doctor: _____

Doctor's Phone #: _____

Child's Allergies: _____

Medicines child is taking: _____

Choice of Specialists: _____

Parents Doctor: _____

Doctors Phone #: _____

Parent(s)/Guardian(s)Medical/Hospital Surgical Insurance Plan is with:

_____

and is effective _____ and is in full force and effect.

The Identification number is: _____

Signature of Parent/Guardian: _____