

HSAA Athletic Release and Medical Authorization

School Year: 2017–2018

Athlete Name: _____ Date of Birth: _____ Grade: _____

Parents Names: _____

Address: _____

City: _____ Zip _____

Phones: Home (____) _____ Work (____) _____ Mobile (____) _____

Other Phone(s): _____

Primary e-mail: _____ Other e-mail: _____

Incorporated in 1997 as a non-profit organization, the Home School Athletic Association desires to provide homeschooled children with the benefits of participation in organized team sports in a setting which honors the God who created them.

EMERGENCY MEDICAL AUTHORIZATION AND AGREEMENT TO CHRISTIAN DISPUTE RESOLUTION

Emergency contacts other than parent or guardian:

1. Name _____ Hm phone _____ Other phone _____

2. Name _____ Hm phone _____ Other phone _____

Permission and Release: I give permission for my child to participate in this activity. I understand that there are risks associated with competitive sports. In the event he/she is injured, I waive and release all rights to any claim for damages against HSAA and its representatives. I further agree that any claim or dispute arising from or related to this agreement shall be settled by mediation and, if necessary, legally binding arbitration in accordance with the *Rules of Procedure for Christian Conciliation* of the Institute for Christian Conciliation, a division of Peacemaker[®] Ministries (complete text of the Rules is available at www.Peacemaker.net). Judgment upon an arbitration decision may be entered in any court otherwise having jurisdiction. The parties understand that these methods shall be the sole remedy for any controversy or claim arising out of this agreement and expressly waive their right to file a lawsuit in any civil court against one another for such disputes, except to enforce an arbitration decision.

Medical Release: In the event my child suffers sudden illness, accident, or injury and neither parents nor guardians can be contacted, I give permission for any emergency treatment that is deemed necessary by a licensed physician.

Family physician _____ Phone _____

Pertinent medical information (diabetes, allergies, etc.): _____

Parent Signature _____ Date _____