ADVANCED MENTORING ENRICHMENT NETWORK

MEDICAL & CIVIL LIABILITY RELEASE FORM

Each participant **MUST** complete this form in its entirety. Signature of parent/legal guardian(s) **REQUIRED** prior to student participation in the Midnight Basketball Program.

Individual registration is not complete unless a Medical & Civil Liability Form is on file with Solutions Services Inc.

Participant Last Name ____________________________ First Name ___________________________ M.I. ________

Street Address ____

City ____ State ___________ Zip Code ________________

Gender: M F (circle one) Date of Birth _________________________

Home Phone ____________________________________ Mobile Phone _____________________________________

Email Address ____

IF PARTICIPANT IS 17 YEARS OF AGE OR YOUNGER:

Parent/Guardian (circle one) Last Name ______________________________ First Name ____________________

Phone Number (home) _________________________________ (mobile) _____________________________________

Emergency Name (PRINT)____ Relationship ____________________

Phone Number (home) __________________________________ (mobile) ___________________________________

MEDICAL INFORMATION

List the name(s) and dosage(s) of any medication participant will be taking while at Solutions Services Inc. __

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List all known allergies (food, medicine, etc.) ____

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List all known medical conditions or activity limitations ____

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Primary Doctor's Name ____ Phone Number________________