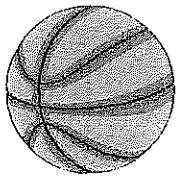
HOLY ROSARY FESTIVAL 2019



3 ON 3 BASKETBALL TOURNAMENT – SUNDAY, JUNE 9

HOW TO ENTER

- Each player must fill out the registration form below and waiver on back completely.
- Entry fee is $40.00 per team and due by May 31 (Make check payable to "Holy Rosary Church").
- Divisions of Play: Grades 4-6, Grades 7-8, Grades 9-12 (*NOTE: Grade entering Fall 2019, ALL PLAYERS ON TEAM MUST MEET GRADE REQUIREMENT, MAXIMUM 4 PLAYERS PER TEAM).
- Check in begins at Noon on Sunday, June 9, tournament begins at 1:00 on church grounds.
- For more info, please contact Michael Schmitmeyer at 419-305-1401 or Schmitmeyerm@gmail.com.

***Please send forms for ALL PLAYERS ON THE TEAM IN ONE ENVELOPE and return with $40 check (made payable to "Holy Rosary Church") by May 31 to:**

Holy Rosary Church
511 E. Spring St.
St. Marys, OH 45885

By signing my name below, I agree to the following:

- I fully agree that I am physically fit & able to participate in the tournament.
- I fully understand that there is a risk of physical injury and I am willing to accept that risk.
- I fully agree that it is my responsibility to understand & obey all rules and laws to ensure my safety.
- In the case of inclement weather, the Festival committee reserves the right to make accommodations as they see fit up to and including cancellation of the tournament.
- I fully understand that any organizations involved in the planning, facilities, & coordination of the tournament as well as any of its sponsors & any associated individuals are not responsible for any loss, injury, or death related to participation or attendance at the HR Festival 3 on 3 basketball tournament.

****FILL OUT BELOW FORM COMPLETELY & BACK SIDE WAIVER IN ORDER TO BE REGISTERED!**

Player Name_____ **Phone #**_____**Grade Fall '19** ____

Email address _____

Emergency Contact and Phone # _____

Signature (if player under 18 then parent/guardian)_____

Team Name _____ **Division** (circle one) **4-6** **7-8** **9-12**

Team Members (include self): **1.** _____

2. _____

3. _____

4. _____

FOR OFFICE USE ONLY			
Paid By:	Amount:	Received On:	Check #:

ARCHDIOCESE OF CINCINNATI
PERMISSION, RELEASE AND
AUTHORIZATION TO SEEK MEDICAL TREATMENT (rev. 09-2017)

1. I, the parent or lawful guardian of _____(the "child"), give permission for my child to participate in the activity described on the *Activity Information* form (the "Activity") and release from all liability and indemnify the Archdiocese of Cincinnati (the "Archdiocese"), the Archbishop of Cincinnati (the "Archbishop"), both individually and as trustee for the Archdiocese, and all parishes and schools within the Archdiocese, and their respective officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, cost and expenses, including attorneys' fees, arising out of any injury or illness incurred by my child while participating in or traveling to or from the Activity and further agree not to bring or prosecute or allow to be brought or prosecuted (including but not limited to prosecution through subrogation) in my name, or on behalf of my Child, any claims, lawsuits or actions against the Archbishop, the Archdiocese, and their respective officers, agents, representatives, volunteers and employees.

2. I further understand that my Child's participation in the Activity is purely voluntary and is a privilege and not a right, and that my Child, and I on behalf of my Child, agree to my Child's participation in the Activity in spite of the risks.

3. I agree to instruct my child to cooperate with the Archbishop or his agents in charge of the activity.

4. I appoint the Archbishop or his agents who are acting as leaders of the Activity to seek medical treatment of my child in the event of any injury, illness or medical emergency occurs during the activity or related travel. I understand that the agents of the Archbishop will make a reasonable attempt to contact me as soon as possible in the event of a medical emergency involving my child.

5. I [ ] agree [ ] do not agree that the Archbishop or his agents may use my child's portrait or photograph for promotional purposes, website and office functions and use social media and technology to communicate to my child regarding ministry related activities.

6. This acknowledgement and release is intended to be as broad and inclusive as permitted by the law of the State of Ohio, and if any portion hereof is declared invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. This acknowledgement and release shall be construed in accordance with the laws of the State of Ohio, except for the choice of law provisions thereof.

I have carefully read and understand and accept the terms and conditions stated herein and acknowledge that this Permission, Release and Authorization to Seek Medical Treatment shall be effective and binding upon me, my Child, and my own and my Child's personal representative or estate, assigns, heirs, and next of kin and that I have signed this agreement of my own free will.

Signature of Parent or Guardian _____ Date __/__/_____

Signature of Witness: _____ Witness Name (please print): _____

Home Address _____ City _____ Zip _____

Place of Employment _____

Work Address _____ City _____ Zip _____

Parent or Guardian Phone No. (cell): _____; (other Phone No.): _____

Emergency Contact Phone No. (cell): _____; (other Phone No.): _____

****

Medical Information — Completed by Parent or Guardian — Please Print

Child's Name _____ Birth date ____/____/_____

Allergies _____

Medications _____

Chronic Conditions (e.g. epilepsy, diabetes) _____

Medical Insurance Co._____ Policy No. _____

Member's Name _____ Phone No. (h) _____ (w) _____

Member's Birth date ____/____/_____

Family Doctor _____ Phone No. _____