PARTICIPANT INFORMATION CARD

Parent or Legal Guardian should complete items one through seven. One information card must be completed for each participant. Participants attending programs at multiple locations must have a separate information card for each program location. Each member or guest that is authorized to check-in or check-out a child must be listed in item 4 on this card. All information cards are confidential and kept on-site for emergency and contact purposes only.

1. Child/Participant Information:			
Child/Participant Name:			**Date of Birth:**
2. Physical Description:			
Gender: **( ) Male** **( ) Female**	**Age:**	**Height**	**Weight**
3. Parent/Legal Guardian Information:			
Name:		**Address:**	
Home Phone #	**E-mail Address:**	**Cell Ph./Alt. Ph. #**	**Membership #**
4. Additional Authorized Sign-In/Sign-Out Person(s):			
B. Name:		**Home Phone #**	**Cell Phone/Alternate #**
C. Name:		**Home Phone #**	**Cell Phone/Alternate #**
5. Emergency Contact Information:			
Emergency Contact Name:		**Home Phone #**	**Cell Phone/Alternate #**
6. Medical Information:			
Medical Insurance Company:		**Policy Number**	
Participants' Physician Name:		**Phone Number:**	
7. Additional Child/Participant Information:			
Allergies: (If no known allergies, please note N/A)			
Other Important Information:			

A._____ _____ _____
Parent/Legal Guardian (Print Name) Signature Date

B._____ _____ _____
Print Name Signature Date

NEXT LEVEL PERFORMANCE

WAIVER FORM

Section I: Participant Information

Name: _____ Parent/Custodian: _____
Address:_____City:_____State:_____Zip_____
E-mail:_____ Phone #(_____) _____ Cell Phone (_____)_____
The best time to contact me is: _____ ☐ A.M. ☐ P.M. On my ☐ Home ☐ Work ☐ Cell
Emergency Contact:_____ Emergency Contact #:_____
Age: _____ Gender:_____ Birthdate_____
Name of School_____ City/State_____
Spouse or Parent's Name: _____
Whom may we thank for referring you? _____
How did you hear about us? _____
Would you like to receive our e-newsletter? ☐ Yes ☐ No

Section II

Authorization for Agent
TO CONSENT TO MEDICAL TREATMENT OF A MINOR AND ACKNOWLEDGEMENT OF RISKS RELEASE AND INDEMNIFICATION AGREEMENT

In the event of and emergency in which my child requires medical care, I authorize the staff of NEXT LEVEL PERFORMANCE to act for me and to obtain for my child whatever medical treatment the staff in its best judgment deems necessary and appropriate. I specifically consent to any X-ray examination, anesthetic medical or surgical diagnosis or treatment and hospital care of _____(name of child) deemed advisable by a licensed physician and surgeon and provided by that physician or under that physician's supervisions, regardless of where the treatment is provided. I will be responsible for any medical or other charges in connection with my child's attendance at the NEXT LEVEL PERFORMANCE Academy or Training Lessons.

Acknowledge of Risks Release and Indemnification Agreement

I acknowledge that at the basketball academy or training lesson my child will participate in a sport or exercises that may involve, among other things, physical contact of the body with other persons or objects, including contact with a hard surface and that at the basketball academy or training lesson, my child may incur a serious injury. In consideration of my child being permitted to participate in the basketball academy or training lesson and to use the program's facilities and equipment, I agree to accept all risk to my child's health and of my child's injury or death that may result from such participation and I release the Next Level Performance, its governing board, members, officers, agents, employees, volunteers, and representative, as well as any facility used for purposes of the basketball academy or training lessons from any and all liability to my child.

Parent/Legal Guardian: _____ Date: _____

NEXT LEVEL PERFORMANCE

Section III **Insurance Information**

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____