OKASA/WHEELCHAIR SPORTS, USA
MEDICAL/WAIVER FORM

Program Name: WATERFEST **Program Date: 8/27/2022**

Name (please print):		Sex:	Date of Birth:
Street Address:			Home Phone:
City:	State:	Zip:	Work Phone:
Email:		Shirt: S M L XL XXL	

Will anyone be accompanying you? ___Yes ___No

If yes, list name: _____

MEDICAL BACKGROUND

Are you presently taking any medications or drugs? ___Yes ___No
If yes, please list and describe:

Medications or drugs to which you are allergic:	Other allergies (i.e., bee stings, poison ivy, etc.)?

Date of last tetanus shot?

Are there any medical conditions or recent injuries that would affect your participation in activities (i.e., allergies, recent breaks or strains, diabetes, etc.)?

DISABILITY INFORMATION

Do you have a physical disability? ___Yes ___No

If yes, complete the rest of this section. If no, skip to "Program Policies."

Disability: _____	If a spinal cord injury, level of injury:

Date of injury:

Have you had a pressure sore within the past year? ___Yes ___No	Is it fully healed? ___Yes ___No
Any problems with dysreflexia? ___Yes ___No	Heat tolerance problems? ___Yes ___No

Describe any other disability related concerns:

PROGRAM POLICIES

Please be aware that OKASA does not allow the possession or consumption of alcohol or drugs during this program. Any infringement of this policy will require you to leave the program.

(PLEASE TURN OVER)

ASSUMPTION OF RISK

I, the undersigned, on behalf of myself, my heirs, assigns, executors and administrators, and next of kin hereby agree that OKASA or any co-sponsoring organization (WSUSA), facility, or its officers, directors, employees, volunteers or agents, shall not assume or have any responsibility or liability for expenses or medical treatment or for compensation for any injury that I may suffer during or resulting from my participation in this program. Further, I the undersigned, on behalf of myself, my heirs, executors and administrators, and assigns hereby agree to waive, release, indemnify, hold harmless and forever discharge OKASA and WSUSA their officers, officials, agents and/or employees ("Releasees") and any co-sponsoring organization, with respect to any and all such injury, paralysis, dismemberment, disability, death, and/or loss or damage to person or property whether caused by the negligence of the Releasees or otherwise, except that which is the result of gross negligence and/or wanton misconduct.

MEDICAL RELEASE FORM

I, the undersigned, agree to accept the responsibility for administering my medication to myself in the manner in which my personal physician has prescribed and only in that manner. I understand that my medication will be kept with my personal belongings to prevent loss of or damage to medication during the program and to prevent anyone else from using my personal medication. I hereby release OKASA their officers, officials, agents and/or employees from all liability regarding my prescribed medication for the dates of this program.

PHOTO CONSENT AND RELEASE FORM

Permission is hereby granted to OKASA to make or have made photographic or other records of the undersigned and to publicize and/or display such photographs and recordings to benefit OKASA. Additionally, I acknowledge and understand that by granting such permission, I understand that OKASA, their officers, officials, agents and/or employees, shall not violate any rights to privacy that I may have and that I waive and release OKASA from any and all causes of action or liability associated with the use of photographic or other recordings.

AUTHORIZATION OF MEDICAL TREATMENT

OKASA or any co-sponsoring organization has permission to obtain a copy of my health record from my primary care physician. I understand that information about my health will be shared on a "need to know basis" with other medical providers. This form may be photocopied.

Primary Care Physician:	
(Name)	(Phone)

If medical care or treatment is needed, I hereby authorize OKASA or any co-sponsoring organization to obtain such care on my behalf and I shall be responsible for all expenses and/or costs associated with such treatment acquired on my behalf, including transportation and/or ambulance service.

In case of emergency notify:		
(Name)	(Relationship)	(Phone)

I have read the above Program Policies, Assumption of Risk, Medical Release, Photo Consent and Release, and Authorization of Medical Treatment policies and sign it freely and voluntarily without any inducement.

Signature: _____ Parent/Guardian (if under 18): _____

Date: _____