MARIMNHEALTH
COEUR D'ALENE TRIBE

Team Registration

Ballin' Back to School | Co-Ed 3on3 Tournament

Team Name: _____ Date of Application: _____

Team Captain Full Name (First, Middle, Last): _____

Mailing Address: _____

City/Zip: _____ Best phone #: _____

Email Address: _____

Teammates

1. _____ AGE: _____ DOB: _____ SHIRT SIZE: _____
2. _____ AGE: _____ DOB: _____ SHIRT SIZE: _____
3. _____ AGE: _____ DOB: _____ SHIRT SIZE: _____
4. _____ AGE: _____ DOB: _____ SHIRT SIZE: _____

Registration Information: 1) This registration form must be complete with a signed "Waiver & Medical Consent" form for each team member. Anyone under the age of 18 must have a signed consent form completed by their legal parent/guardian. 2) Each team must consist of 3 or 4 players. All games must start with three players, with one female player on the court at all times. 3) Teams will be divided into divisions according to age. False information will be grounds for dismissal from the tournament. Brackets and divisions are tentative and may be adjusted as necessary. 4) Adverse weather or unplayable conditions may result in modification or cancellation of the tournament.

All games will be played at the Worley City Park (30000 S 3rd St., Worley, Idaho).

Complete applications can be emailed to wellbriety@marimnhealth.org or dropped off at the Wellbriety office located at the Marimn Health Wellness Center (1100 A Street, Plummer Idaho 83851). Registration closes August 23, 2024.

By participating in this tournament, you agree to the team pledge below.

I realize that I am responsible for my own and my teammates' conduct of play. I vow to present myself and represent my team in a sportsmanlike manner. If I fail to do so, I realize that both my team and I may be ejected from the tournament.

Individual Waiver & Medical Consent Form

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All players are required to complete and return a waiver and consent form by August 23, 2024.

Authorization for Consent to Medical Treatment

I, the undersigned, do hereby authorize any x-ray examination, anesthesia, medical or surgical diagnosis or treatment diagnosis or treatment and hospital service that may be rendered to myself under general or special instructions of the family physician, _____, whether such diagnosis and/or treatment is rendered at the office of said diagnosis and/or treatment is rendered at the office of said physician or at a hospital. In the event there is no family physician, I authorize representatives of Marimn Health to secure appropriate medical attention at the nearest medical facility available. It is understood that this consent is given in advance of any specific diagnosis or treatment being required and said physician to exercise his or her best judgment as to requirements of such diagnosis or treatment.

This shall remain in effect for the day of this event and the duration of any medical emergency that may arise from participation in this event, unless sooner revoked in writing by the undersigned.

Medical Information

Allergies (drug or food)

_____

_____

Current Medication(s) child is taking

_____

_____

Any Current Health Problem (ex. Asthma, Diabetes)

_____

_____

Family Physician

_____

Address _____ Phone _____

Dentist

_____

Address _____Phone _____

Waiver

I understand that Marimn Health assumes no responsibility for injuries of illnesses which I may sustain as a result of my physical condition or resulting from my participation in any athletic activities, sports, programs, and the use of any equipment, exercise or other activities. I expressly acknowledge on behalf of myself and heirs that I assume the risk for any and all injuries and illnesses which may result from participation in these activities. I hereby release and discharge Marimn Health, its agents, servants, and employees from any and all claims for injury, illness, death, loss or damage which I may suffer as a result of my participation in these activities. I understand that Marimn Health is not responsible for personal property lost or stolen while members and/or program participants are using Marimn Health. I give my permission to Marimn Health to use indefinitely, without limitation or obligation, photographs, film footage or tape recordings which may include my image voice for purpose of promoting or interpreting Marimn Health programs. Nothing in this waiver shall be construed to in any way limit the sovereign immunity of the Coeur d'Alene Tribe.

_____

(Print name of participant)

_____

(Print name of parent if under 18)

_____ _____

(Signature of participant or parent if under 18) Date

PLEASE RETURN THIS WAIVER & MEDICAL TREATMENT CONSENT FORM BY AUGUST 23, 2024 via email at wellbriety@marimnhealth.org or in-person at the Wellbriety office located at the Marimn Health Wellness Center (1100 A Street, Plummer, Idaho).