

Member / Volunteer Application

The Disabled Sailing Association of Alberta provides disabled Albertans with the opportunity to access and enjoy sailing activities while promoting enhanced independence and community involvement.



Please Print: Membership Year _____

Type of application: New Renewal Volunteer

Membership priority: Sailing Volunteering Supporting

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Email: _____

Home Phone: _____ Cell Phone: _____

Disability: Not Applicable

Specify: _____

I DO NOT WANT my information published for access by other Members

I would like to receive DSAA notices, AHOY newsletters, etc. by E-MAIL ONLY

Applicant Signature: _____ OR Parent / Guardian: _____

For DSAA Use Only

Participant Release / Medical Form on file, dated: _____

Paid by: Cash, or Cheque # made out to the Disabled Sailing Association of Alberta

Received by: _____ Date: _____

Comments:

Information is gathered for the express use of the Disabled Sailing Association of Alberta and is governed by legislation under FOIPP (Freedom of Information and Protection of Policy Act) www.gov.ab.ca/ascii/ACTS/WPD/F18P5.XT

Disabled Sailing Association of Alberta

P.O. Box 72136, RPO Glenmore Landing, Calgary, Alberta, T2V 5H9 403-225-8050 www.dsaalberta.org

**PARTICIPANT RISK ACKNOWLEDGEMENT, RELEASE,
WAIVER OF CLAIM AND ASSUMPTION OF RISK**



Participant's Name: _____

Participant's Age: _____ (if minor)

Parent / Guardian: _____ Relationship: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

In consideration of permission granted to participate in the Programs of the Disabled Sailing Association of Alberta (DSAA), I agree and acknowledge that:

1. I will abide by the rules imposed on the participants in the Program, and the instruction given or decisions made by the DSAA Staff.
2. I freely and voluntarily assume any risk and hazards inherent in the nature of the program and accordingly my participation shall be entirely at my own risk.
3. I waive any claim I have against the DSAA, its executive or its members, arising from my participation in the program and agree to indemnify and save harmless the DSAA, including any claim for medical services arising from my participation in the program.
4. The DSAA may secure any medical advice and services as the DSAA staff, in his/her sole discretion, may deem necessary for my health and safety and I shall be financially responsible for the cost of such advice and services.
5. This RELEASE, WAIVER OF CLAIM AND ASSUMPTION OF RISK is binding upon myself, my executors, my guardians, administrators, and personal representatives

Dated at _____, Alberta this _____ day of _____, 20_____

Signature of Participant Given name Surname Witness

Parent/Guardian if Required Given name Surname Witness

YOU MAY DUPLICATE THIS FORM AS REQUIRED / BOTH SIDES OF THIS FORM MUST BE COMPLETED

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MEDICAL INFORMATION



This information is confidential and collected only to ensure the safety of the participant and DSAA staff. Medical information will only be used and shared with medical personnel in the event of a medical emergency

Participant's Name _____

Age: _____ Weight: _____

Emergency contact name: _____ Phone: _____

Doctor's name: _____ Phone: _____

Current medications: _____

Allergies: _____

Physical limitations or barriers to participation: (fear of water, motion sickness, etc.)

Mobility or transfer considerations: (paralysis, low muscle tone, hyper-sensitivity, etc.)

Communication and/or cognitive barriers: _____

Other pertinent medical conditions: (sensitivity to sun, exposure, etc.) _____

Comments: _____

Signature of Participant: _____ **Date:** _____

Signature of Parent/Guardian _____ **Date:** _____

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