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_____ Age (if minor)_____

Parent/Legal Guardian (if applicable)_____ Relationship_____

Address_____

City_____ Prov._____ Postal code_____

Phone _____ email_____

In consideration of permission granted to participate in the Programs of the Disabled Sailing Association of Alberta (DSA-A), 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 DSA-A Staff.
2. I freely and voluntarily assume any risk and hazards inherent in the nature of the program and accordingly my participation in the program shall be entirely at my own risk.
3. I waive any claim I have against the DSA-A, its executive or its members, arising from my participation in the program and agree to indemnify and save harmless the DSA-A, including any claim for medical services arising from my participation in the program.
4. The DSA-A may secure any medical advise and services as the DSA-A 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, personal representatives and assigns.

Dated at _____, Alberta this _____day of _____, 20____

_____	_____	_____	_____
Signature of participant	**Given name**	**Surname**	**Witness (signature)**

_____	_____	_____	_____
Signature of guardian	**Given name**	**Surname**	**Witness (signature)**

BOTH SIDES OF THIS FORM MUST BE COMPLETED

YOU MAY DUPLICATE THIS FORM AS REQUIRED

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

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MEDICAL INFORMATION

This information is confidential and collected only to ensure the safety of the participant and DSA-A 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_____

Doctors 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 guardian/parent_____ **Date**_____

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