



WASHINGTON INTERNATIONAL SCHOOL
SUMMER BASKETBALL CLINICS 2026
PARTICIPANT AUTHORIZATION AND RELEASE

This Authorization and Release (the "Form") must be completed and signed where indicated by the parent(s)/legal guardian(s) of each child enrolled in the Washington International School Summer Basketball Clinic to be held between June 29–July 31, 2026 (the "WIS Clinic").

Participant's Name: Preferred Name:
Address: City/State/Zip:
Date Of Birth: Gender:
School: Grade Entering In Fall:

Parent/Legal Guardian #1:
Address: City/State/Zip:
Home Phone: Work Phone:
Cell Phone: E-Mail:

Parent/Legal Guardian #2:
Address: City/State/Zip:
Home Phone: Work Phone:
Cell Phone: E-Mail:

Participant Lives With: o Parent/Legal Guardian #1 o Parent/Legal Guardian #2
o Both Parents/Legal Guardians o Other:

EMERGENCY CONTACT

Please list two Emergency Contacts (other than the parent(s)/guardian(s) listed above) for the Participant.

Name: Relationship: E-Mail:
Address:
Home Phone: Work Phone: Cell Phone:
Name: Relationship: E-Mail:
Address:
Home Phone: Work Phone: Cell Phone:

HEALTH INFORMATION

Washington International School requires all participants to present a report of a physical examination conducted during the preceding eighteen (18) months and a certificate of up-to-date immunizations, or a certificate of exemption from each requirement, before attending the WIS Clinic. In addition, I am responsible for providing the WIS Clinic with the name of the carrier and policy number that insures the Participant and to notify the WIS Clinic if this coverage changes. I understand and agree that I am responsible for the costs of medical care for the Participant while the Participant is enrolled in the WIS Clinic.



Participant's Health Insurance: _____

Policy Holder: _____ Policy Number: _____

Primary Care Physician: _____ Phone: _____

Dentist/Orthodontist: _____ Phone: _____

Health Concerns/Allergies: Please indicate if the Participant has any health concerns and/or allergies.

o Asthma: _____

o Allergies: _____

o Other: _____

Explanation And Symptoms: _____

Prescribed Medications: _____

Medication Administration: Whenever possible, parents and physicians are encouraged to schedule medication to be taken outside of program hours. If the Participant will need to take any medication(s) while participating in the WIS Clinic, the Participant must provide the following to **Chase Bruggeman** prior to the commencement of the WIS Clinic: (1) written authorization from the prescribing physician(s); (2) the appropriate container(s) of medication(s) in properly labeled pharmacy- or manufacturer-provided containers; and (3) any supplies necessary to administer the medications. By signing this Form, I am authorizing the WIS Clinic to administer the medication(s) to the Participant.

Participant will require medication(s) while at the WIS Clinic (includes prescription and over-the-counter):

o No. o Yes. If YES, please describe:

Name of Medication: _____

Dosage of Medication: _____

Date(s)/Time(s) to Administer Medication or Symptoms that Require Medication to be Administered:

Accuracy Of Information: Information about the Participant contained on this Form and provided in addition to this Form is correct and current to the best of my knowledge. I understand and agree that if the Participant's health information, insurance, or emergency contact information changes after the completion of this Form and before the completion of the WIS Clinic, I will promptly provide updated information to **Chase Bruggeman**.

AUTHORIZATION FOR TREATMENT

In case of a health problem or emergency, I authorize the WIS Clinic to administer first aid and, where necessary, to transport or arrange for the transportation of the Participant to the nearest hospital emergency room if needed and to release any records necessary for care or insurance purposes. I understand that the WIS Clinic or its employees or representatives will, to the extent reasonably possible, consult with me concerning any medical care to be provided to the Participant. Absent my direct instructions, I hereby authorize Washington International School and/or WIS Clinic employees or representatives to permit commencement of medical treatment, medical testing, or hospital care (including necessary transportation) when, in the judgment of the medical personnel involved, such treatment is medically necessary, even if I have not yet been consulted. In authorizing such emergency treatment, I agree to accept the determination of the treating medical personnel that the treatment or care rendered was medically necessary to protect the life, health, or mental well-being of the Participant. I hereby agree to bear all costs incurred as a result of the foregoing.





PARENTAL CONSENT TO PARTICIPATE AND WAIVER OF LIABILITY

In consideration of the Participant's participation in the WIS Clinic, I, the undersigned, acknowledge, understand, and agree as follows.

The Participant has my permission to participate in the WIS Clinic as described in the WIS Clinic webpage. These include, but are not necessarily limited to, athletic instruction, stretching, focused drills, games, and scrimmages, running and exercising, physical training, and other sport-specific instruction. I have considered and disclosed to the WIS Clinic all physical or mental health conditions, and any risks associated with any such conditions, that could potentially affect the Participant's ability to safely participate in the WIS Clinic. My permission for the Participant to participate in the WIS Clinic is based upon my belief that the Participant does not have a physical or mental health condition that could affect the Participant's ability to safely participate in the WIS Clinic. If any such concerns arise (whether based on my review of the day trips' itineraries or otherwise), I agree to promptly disclose any concerns and associated risks to **Chase Bruggeman**.

I understand that the Participant's participation in the WIS Clinic may expose the Participant to certain risks including, without limitation: the potential negligence of the Releasees (as defined below) or other parties; inappropriate conduct or negligence by self or others; misjudgment by self or others; misuse of the WIS Clinic's equipment; overexposure to natural elements; participants' mental, physical, or emotional conditions (known or unknown, disclosed or undisclosed); falling down or slipping; animal hazards, such as stings, bites, poisoning, and blows; contraction of communicable disease; burns; risks and physical injuries associated with sports (including, but not limited to, strains, muscle pulls, broken bones, concussions, etc.); and acts of God and criminal acts. By signing this Form, I acknowledge that I have had the opportunity to ask questions and obtain whatever information I require to fully inform myself about the WIS Clinic, including the risks that the Participant may be exposed to while participating in the WIS Clinic.

RELEASE. I agree, on my own behalf and that of the Participant and our heirs, executors, administrators, personal representatives, and/or assigns (the "Releasers"), to forever release, acquit, discharge, covenant to hold harmless, and covenant not to sue Washington International School, the WIS Clinic, and their respective trustees, employees, volunteers, representatives, and agents ("Releasees") from any and all claims, suits, liabilities, and actions, including, but not limited to, any negligence of the Releasees, which Releasers may have, now or in the future, which arise directly or indirectly out of the Participant's participation in the WIS Clinic.

I understand that this Release includes, but is not limited to, any and all claims, suits, liabilities, and actions, that may arise directly or indirectly out of: (a) the financial losses that I or the Participant may incur in connection with the cancellation or rescheduling of the WIS Clinic; (b) any services related to the special or emergency needs of the Participant while participating in the WIS Clinic; and/or (c) any authorized administration or assistance in administration of medications to the Participant.

ASSUMPTION OF RISK. I am familiar with the WIS Clinic, and I fully understand, accept, recognize, and appreciate the risks and dangers associated with the Participant's participation in the WIS Clinic, including, but not limited to, the risks identified above. I recognize that participation in the WIS Clinic could result in property loss or damage, serious bodily injury, contraction of communicable illness, paralysis, and even death. While rules, equipment, and personal behavior may reduce the likelihood of injury, the risks and dangers of bodily injury still remain. I hereby knowingly and freely assume, on behalf of myself and the Participant, all risks, both known and unknown, associated with participation in the WIS Clinic.

INDEMNIFICATION. I hereby agree, on behalf of myself and the Participant, to indemnify the Releasees from and against any and all demands, claims, suits, actions, causes of action, or liabilities, including attorneys' fees, brought by any person or entity, arising directly or indirectly from the Participant's participation in the WIS Clinic, including, but not limited to, any injury of any person or damage to or destruction of any property caused by the Participant.



WAIVER. To the extent any claim is made by any person or entity against any of the Releasees in connection with the Participant’s participation in any WIS Clinic activities, I hereby waive, on behalf of myself and the Participant, any claim for or right to monetary damages or any other form of personal relief.

WARRANTY OF INSURANCE. Even though there are risks associated with participation in the WIS Clinic and the possibility of additional risks of which neither the WIS Clinic nor I may be aware, I represent and warrant that I have enrolled the Participant in any and all insurance, including, but not limited to, health care, accident, and personal property insurance that I believe, in my sole judgment, is necessary to protect the Participant and the Participant’s interests.

The provisions contained above include any property or personal loss or damage, or other loss caused or alleged to be caused, in whole or in part, by the ordinary negligence (but not gross negligence) of the Releasees. These provisions are not intended to, and do not, govern any claims that cannot be released by private agreement.

* * * * *

I, the undersigned, have read the entirety of this Form, I have satisfied myself that I understand what it means, and have accepted all the Form’s terms and conditions. I hereby expressly agree that the provisions contained in this Form are intended to be as broad and inclusive as permitted by the laws of the District of Columbia and that if any portion hereof is held invalid or unenforceable, I agree that the balance shall continue in full legal force and effect.

By signing this Form, I affirm that I have legal custody of the Participant, am authorized to sign on the Participant’s behalf, and have decided to allow the Participant to participate in the WIS Clinic with full knowledge that the Releasees will not be liable for any personal injury or property damage the Participant may suffer or cause, while participating in the WIS Clinic.

I understand that this Form may be electronically signed, and by indicating my assent below, I am agreeing to the use of electronic signatures. I understand and agree that my electronic signature will have the same legal effect and validity as a written signature, and that this Form is valid and will be given the same legal effect as a written and signed Form.

Parent/Legal Guardian #1 (Please Print) Signature Date

Parent/Legal Guardian #2 (Please Print) Signature Date

