



Disabled Sailing Association  
of British Columbia

# Sailor Registration Form

**Please forward this application to**

Disabled Sailing Association  
Suite 318 - 425 Carrall Street  
Vancouver, BC V6B 6E3

Phone: 604-688-6464 ext. 132

Fax: 604-688-6463

[info@disabledsailingbc.org](mailto:info@disabledsailingbc.org)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (work): \_\_\_\_\_

Cell phone: \_\_\_\_\_ Email: \_\_\_\_\_

**We make all program updates via email**

## MEDICAL INFORMATION

Nature of disability: \_\_\_\_\_

Mobility Aids:  Wheelchair  Scooter  Crutches  Cane  Other: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Family doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of birth: \_\_\_\_\_ BC Care Card No.: \_\_\_\_\_

## EMERGENCY CONTACTS

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

Do you know of anyone interested in volunteering with DSA? \_\_\_\_\_

\_\_\_\_\_

# Participant's Release of Liability, Waiver of Claims, Medical Waiver, Assumptions of Risks and Indemnity and Image Consent

By signing this document, you will waive certain legal rights including the right to sue. Please read carefully.

## ASSUMPTION OF RISKS

**I AM AWARE THAT THERE IS POTENTIAL RISK FOR PERSONAL INJURY INVOLVED IN PARTICIPATION IN ANY PHYSICAL ACTIVITY.** I freely accept and fully assume all such risks, dangers and hazards, including the possibility of personal injury (including but not limited to: **bumps, bruises, cuts, scrapes, concussion, broken bones, infections, abrasions and hypothermia**), death and/or property loss resulting from my participation in this Disabled Sailing Association (DSA) activity.

I am also aware that I should discuss my participation in this activity with my physician to determine the effect on my current health.

## RELEASE OF LIABILITY, WAIVER OF CLAIMS AND INDEMNITY AGREEMENT

In consideration of approval to participate in DSA's activities, I hereby agree as follows:

\_\_\_\_\_ **Initial** **TO WAIVE ANY AND ALL CLAIMS** that I have or may in the future have against DSA, its directors, officers, employees, volunteers, representatives, other participants and partner organizations (Sam Sullivan Disability Foundation and its affiliated societies, City of Vancouver, Jericho Sailing Centre, Vancouver Board of Parks and Recreation, False Creek Yacht Club) all of whom are hereinafter collectively referred to as "The Releasees";

\_\_\_\_\_ **Initial** **TO RELEASE THE RELEASEES** from any and all liability for any loss, damage, injury or expense that I suffer, or my next of kin may suffer as a result of my participation in this activity due to any cause whatsoever **INCLUDING NEGLIGENCE, BREACH OF CONTRACT OR BREACH OF ANY STATUTORY OR OTHER DUTY OF CARE.** I acknowledge my responsibility to ensure adequate medical, personal health, dental and accident insurance coverage, as well as protection of my personal possessions;

\_\_\_\_\_ **Initial** **TO HOLD HARMLESS AND INDEMNIFY THE RELEASEES** from any and all liability for any damage to property of, or personal injury to, any third party resulting from my participation in DSA activities;

\_\_\_\_\_ **Initial** This agreement shall be effective and binding upon my heirs, next of kin, executors, administrators, assigns and representatives in the event of my death or incapacity;

\_\_\_\_\_ **Initial** In entering into this Agreement, I am not relying upon any oral or written representations or statements made by the Releasees other than what is set forth in this Agreement;

\_\_\_\_\_ **Initial** I grant permission to DSA and/or their designates to proceed in any manner they deem necessary in the case of medical emergency involving myself (or my child/ward). I am releasing the right for this information to be shared with DSA volunteers, staff, and/or medical staff who are in contact or responsible for my (or my child / ward's) participation in the program;

\_\_\_\_\_ **Initial** DSA and/or their designates often take photographs/videos of participants and staff while programs are operating. These pictures may be used for promotional purposes, training, and public education. I give my permission for photographs/videos to be taken of myself / my child / ward, and for these to be subsequently published.

**I HAVE READ AND UNDERSTAND THIS AGREEMENT AND I AM AWARE THAT BY SIGNING THIS AGREEMENT I AM WAIVING CERTAIN LEGAL RIGHTS WHICH I OR MY HEIRS, NEXT OF KIN, EXECUTORS, ADMINISTRATORS AND ASSIGNS MAY HAVE AGAINST THE RELEASEES.**

**Date:** \_\_\_\_\_

**Participant Signature:** \_\_\_\_\_ **Print Name:** \_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_ **Print Name:** \_\_\_\_\_  
(If participant is under 19 years of age)

**Witness:** \_\_\_\_\_ **Print Name:** \_\_\_\_\_

IF YOU ARE SIGNING FOR SOMEONE 19 YEARS OF AGE OR OLDER, DO YOU HAVE LEGAL COMMITTEESHIP or a REPRESENTATION AGREEMENT IN PLACE? **YES / NO** \_\_\_\_\_ **INITIALS** \_\_\_\_\_