Skyline Lacrosse Club
Medical Release and Liability Waiver

Player Name:_____ DOB:_____

Street Address:_____ Grade:_____

City/Zip:_____ School:_____

PARENT or GUARDIAN AUTHORIZATION:

In case of an emergency, if our family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (EMT, First Responder, ER Physician).

Family Physician:_____ Phone:_____

Hospital Preference:_____

Insurance Company:_____

To ensure that medical personnel have details of any medical problem which may interfere with or alter treatment, please list allergies/medical problems, including those requiring maintenance medication (asthma, diabetic, seizures, etc.):

MEDICAL DIAGNOSIS MEDICATION DOSAGE FREQUENCY

_____

_____

In case of an emergency, if you parent/guardian cannot be reached:

_____

Name Relationship Phone

_____

Name Relationship Phone

By signing this form, I hereby assume all risks and hazards incidental to participation in lacrosse activities and do hereby waive, release, absolve, indemnify and agree to hold harmless the Skyline Lacrosse Club, Issaquah School District, instructors, volunteers and their heirs for any claim arising from the participation of my child in the Skyline Lacrosse program. I authorize the instructors and staff to act in their best judgement in any emergency requiring medical attention.

_____

Signature of Parent/Guardian Date

_____

Printed Name Of Parent/Guardian Cell Email