WARRIOR ATHLETIC CLUB

MEDICAL HISTORY, INFORMED CONSENT, AND RELEASE FORM

I hereby give my permission for_______________________________ to participate on the Warrior Athletic Club Softball Team. Further, I authorize the coaching staff to provide emergency medical treatment of an injury to or illness by my child if qualified medical personnel consider treatment necessary. I further authorize any qualified, licensed physician to render medical treatment which in his or her judgment may be deemed necessary.

This authorization is only granted if I cannot be reached and a reasonable effort has been made to do so.

____

Parent/Legal Guardian's Signature Date

PERSONAL INFORMATION

Name:____ Age:___________ Birth Date:_________________

Street Address:____

City/State/Zip:____

Home Phone:_____________________ Work Phone:_____________________ Cell Phone:_____________________

Other person to be contact in case of an emergency:____

Relationship to player:___________________________________ Phone:___________________________________

MEDICAL INFORMATION

Players Physician:____ Phone:_____________________________

Hospital Preference:____ Phone:_____________________________

Date of last tetanus shot:______________________________ Wear Glasses:_________ Wear Contacts: ________

Medications taken regularly:____

Known allergies/drug reactions:____

Pertinent existing physical information: (diabetes, seizures, head injury, unconsciousness and/or confusion): _

____

Previous serious injuries (date and nature):____

INSURANCE INFORMATION

Insurance company:____ Policy #:_________________________

Subscriber's name:____

Place of Employment:____ Phone:___________________________

This form will be on file with the Warrior Athletic Club Coach throughout the season.