

2009-2010 Season
U-19 RUGBY CLUB

**EMERGENCY INFORMATION/ MEDICAL RELEASE
FORM
CONSENT FOR EMERGENCY TREATMENT**

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____, Zip: _____

Date of Birth: ____/____/____ Age: _____ American Citizen (Yes/No): _____

Parent/Legal Guardian: _____ Emergency Contact Phone Number (____) _____

In order to compete in Rugby, all players **MUST** undergo a physical evaluation and seek health/medical insurance coverage with a requirement of \$100,000 as required by the **WAIVER OF LIABILITY AND ELIGIBILITY FORM**. Rugby is a contact sport and **RISKS OF SERIOUS INJURY DO EXIST** including permanent disability, paralysis and death; these risks and dangers may be caused by a participant's actions or inaction's, action or inaction's of others in the Activity, or the condition in which the Activity takes place. Emergency information provided by the participant and his/her parent or legal guardian is essential in case of an accident or injury. The signature below confirms that all information provided is complete and accurate.

Parent/Legal Guardian Signature: _____ Date: ____/____/____

Student-Athlete Signature: _____ Date: ____/____/____

#1 Emergency Contact Name _____ Relationship: _____

Home Address _____ Home Phone _____

_____ Work Phone _____

_____ Cell Phone _____

Preferred Way to Contact _____

#2 Emergency Contact Name _____ Relationship: _____

Home Address _____ Home Phone _____

_____ Work Phone _____

_____ Cell Phone _____

Preferred Way to Contact _____

MEDICAL EMERGENCY AND INSURANCE INFORMATION

Physician: _____ Physician Phone Number: _____

Insurance Provider: _____ Group Number: _____

Policy
Number: _____

Current Medications: _____

Known Allergic Reactions: _____

Pre-existing medical conditions: _____

Preferred Hospital: _____

PARENTAL CONSENT AND INDEMNIFICATION AGREEMENT

I, the minor's parent and/or legal guardian authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed by available medical staff and/or a licensed physician when deemed necessary or advisable by appointed representatives in case of my absence. I waive my right of informed consent to such treatment and release from any litigation expenses, attorney fees, loss liability, and damage or cost any Releases may incur as the result of any such claim.

Student-Athlete Signature _____ Date _____

Parent/Guardian Name (Please Print) _____

Parent/Guardian Signature _____ Date _____