Warriors Medical Release

Participant Name: ______________________

Mother Cell: ______________ Father Cell: ______________

Physician Name: ______________________

Physician Phone: ______________________

Insurance Company: ______________________

Athlete Medical Information

Please list any medical conditions that we need to be aware of

Please list any medications your child is currently taking

Please list any known allergies

Emergency Contact

Person to be notified if parent or guardian cannot be reached in an emergency

Full Name: ______________________

Relationship to athlete: ______________________

Cell Phone: ______________________

Alternate Phone: ______________________

Parent Consent

In case of a medical emergency during a WAHAA-related activity, I hereby give permission to WAHAA coaches or the athletic director to order treatment for my child, including any necessary medical treatment and x-rays. I also hereby give permission to WAHAA coaches/athletic director to disclose information concerning my child to medical personnel. I understand that an attempt will be made to reach me by phone in case of such emergency. I agree to pay all medical, hospital, or other expenses which my child may incur as a result of such treatment.

I/We have read, understand, and agree to comply with the Parent Consent as outlined above.

Parent Signature: ______________________ Date: ______________