Knightmares Rugby

Medical Release

PLEASE PRINT

I hereby give my permission for any and all medical attention necessary to be administered to
My child (first name) ____________________________ (last name)_______________________________________
In the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted, this release is effective for a period of one year from the date given below. I also assume the responsibility for the payment of any such treatment, including, but not limited to transportation for required treatment.

PARENT/GUARDIAN: ________________________________ ____________________________________

ADDRESS: ____ **RELATIONSHIP:** _______________________

CITY: _____________________________________ **STATE:** ____________________ **ZIP:** ________________

HOME PHONE: _________________ **OFFICE PHONE:** __________________**CELL:** _________________

PAGER: ________________________ **OTHER**____________________

NAME OF INSURANCE COMPANY: ______________________________ **AGENT:** _________________

POLICY NUMBER: ____________________________________ **GROUP NUMBER:** ____________________

TYPE: _____________________________

In case I cannot be reached, any of the following people are designated to act on my behalf**:**
1. COACH: ____
2. ASSISTANT COACH/MANAGER: ____
3. Any event representative where my child is participating.
4. Team parent: ____

In case I cannot be reached, please call ________________________________ at ___________________________

OUR PHYSICIAN'S NAME: ____

ADDRESS: ____

CITY: ___________________________________ **, MI. ZIP:** ________________________

PHONE NUMBER: __________________________ **HOSPITAL:** _____________________________________

KNOWN ALLERGIES: ____

KNOWN DISABILITIES: ____

OTHER IMPORTANT MEDICAL INFORMATION:

____

____

Signature of Parent/Guardian: ____ **Date:** ________________