

Hempfield Rugby Football Club



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:** _____