PARENTAL AUTHORIZATION MEDICAL RELEASE FORM FOR PARTICIPATION IN IRON HORSE ATHLETICS ACTIVITIES

PLEASE PRINT CLEARLY. ILLEGABLE FORMS WILL BE DECLINED

I, as the parent or guardian of (player's full name) _____, do hereby give my approval for their participation in any and all IRON HORSE ATHLETICS (IHA) activities. I hereby grant my permission to managing personnel or other IHA representatives to authorize and obtain medical care, at my expense, from any licensed physician, hospital or medical clinic should the player become ill or injured while participating in IHA activities away from home, or where neither parent or legal guardian is available to grant authorization for emergency treatment. I assume all risks and hazards incidental to my child's participation, including transportation to and from the activities; and do hereby waive, release, absolve, indemnify and agree to hold harmless the local league organization, IRON HORSE ATHLETICS, All Saints Academy, the organizers, sponsors, supervisors, participants and persons transporting the player to and from the activities, for any and all claims arising out of an injury or illness to the player. I further agree to return upon request the uniform and other equipment issued to the player in as good a condition as when received, except for normal wear and tear from league activities. Parents will be financially responsible for lost or damaged uniforms and equipment outside of normal wear and tear.

Accident/Health insurance for this player is provided by: Insurance Company:

_____

Policy or Certificate Number: _____

Signature of Parent or Legal Guardian: _____

Relationship: _____

Date: ____ / ____ / _____

Emergency Contact 1: _____ Relationship: _____ Phone#: _____

Emergency Contact 2: _____ Relationship: _____ Phone#: _____

Allergies (Food, Medication): _____

Medical History (Please list all conditions past and current): _____

_____

_____

_____

Is the participant on medication? (If yes, list meds): _____

Add list as attachment if more space is required

Primary Care Physician: _____ Phone #: _____