WMASS HKY Field Hockey Clinics Liability Consent Form

Name ___________________________________ Date of Birth __________________
Phone # _________________________________

Release and Medical Authorization

This is to certify that ____ has been examined by a physician within the past year, and that he was found to be physically able to participate in vigorous physical activity and competitive athletic sports.

Date of last tetanus shot ____

Any known allergies ____

Any medical problems we need to be aware of:

____

Any medications you are currently taking:

____

Is an identification band or card carried to alert others to allergy(ies), medical conditions or medication use? ______________________________

If so, please explain:

____

Release of Liability and Medical and Surgical Authorization

In consideration of being permitted to participate in WMASS HKY Field Hockey Clinics, I hereby assume the risks of personal injury that may result from program activities. I am knowledgeable about the sport, have previously participated in the sport, and am aware of the potential for injury while participating. WMASS HKY Field Hockey Clinics will not be responsible for personal injury that results from negligent acts or omissions of the Camp employees. As a participant and/or parent or guardian, I do herby release WMASS HKY Field Hockey Clinics and its employees from all liability for personal injury or property damage which results from causes beyond the control of, and without the fault or negligence of, WMASS HKY Field Hockey Clinics and its employees.

I hereby authorize and give my consent to the health care providers to perform upon or administer to ____
(camper's name) any reasonable, necessary surgical or medical treatment. I also give permission to administer whatever anesthetic may be necessary or advisable during the medical or surgical procedures. This authorization is intended to cover emergency treatment, immunizations, injections and minor operations and procedures.

I understand that WMASS HKY Field Hockey Clinics offers an excess insurance for injuries as a result of and that all claims must first be filed with my primary insurance in order to be eligible for this excess coverage. I authorize my insurance company to pay benefits to the health care providers that Camp employees send my child to for evaluation and treatment. I authorize the disclosure of medical information to my insurance company and to the WMASS HKY Field Hockey Clinics excess carrier for the purpose of a claim.

This permission is good only while the student is attending WMASS HKY Field Hockey Clinics and only until the student has turned 18 years of age.

Parent or Guardian ____Date___________
Player ____Date ___________

Insurance Company ____

Address____
____

Policy number____

Policy holder ____