CVYLAX 2017 Emergency Medical Waiver

Player Last Name _____ Player First Name _____ Date of Birth _____ U-level _____ Contact email _____

Street Address _____ City/State _____ Zip Code _____

Parent/Guardian 1, Name _____ Primary Phone Number _____ Other Phone Number _____

Parent/Guardian 2, Name _____ Primary Phone Number _____ Other Phone Number _____

Parent/Guardian 1, Email _____ Parent/Guardian 2, Email _____

Insurance Company _____ Policy Number _____ Group ID Number _____

Primary Doctor _____ Phone Number _____ Preferred Hospital _____

Please list any known allergies or medical conditions (Please continue on back if more space is needed):

_____

_____

Please list any medications your player is currently prescribed (Please include; Inhaler, Epi Pen, etc…):

Medication Name _____ Dosage _____ Medication Name _____ Dosage _____

Medication Name _____ Dosage _____ Medication Name _____ Dosage _____

Emergency Contact Information:

Name _____ Relationship _____ Primary Phone Number _____ Other Phone Number _____

Consent for Treatment:

As the parent/legal guardian of _____, I request that in my absence the above-named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

Parent/Guardian Signature _____ Date _____

TLP, 10/2014