

Mercer Island Girls Lacrosse Program

Medical Consent, Release and Waiver of Liability, Assumption of Risk and Indemnity Agreement (Parental Consent of Minor)

I certify that I am the parent/guardian of _____ and that I have enrolled her in a lacrosse program sponsored by the Mercer Island Women's Lacrosse Club (the Club). By enrolling her in this program, I certify that she is in good health and is able to participate in all activities that take place associated with this lacrosse program. I further certify that she and I are aware of all of the inherent dangers of participating in lacrosse and that she will to the best of her ability, play under control and avoid injury to herself and others.

For and in consideration of the right for my child/ward to participate in this lacrosse program, I hereby assume all associated risks and will hold harmless the Club and its directors, officers, coaches, instructors, agents and/or volunteers from any and all liability, actions, causes of action, debts, claims, demands of every kind and nature whatsoever that may arise out of or in connection with my child's/ward's participation in any activities associated with this lacrosse program.

I authorize all first aid, medical, dental, surgical, diagnostic, and hospital procedures as may become necessary for my child/ward. I accept full responsibility for the cost of treatment for any injury or illness suffered by my child/ward while taking part in this lacrosse program. I agree to this medical consent and release and waiver of liability in consideration of the opportunity for my child to participate in this lacrosse program.

The terms hereof shall serve as a release and assumption of risk for my heirs, executor and administrators and for all members of my family including any minors accompanying me. I have agreed to this document as my own free act and if I have any doubts concerning the contents of this release agreement, I will consult with an attorney before I agree to it.

Printed Name of Parent

Printed Name of Participant

Signature of Parent

Date

Home Phone #1 _____

Home Phone #2 _____

Cell Phone #1 _____

Cell Phone #2 _____

Work Phone #1 _____

Work Phone #2 _____

Emergency Contact Phone # _____

Allergies _____

Immunizations up to date: Yes _____ No _____

Health Problems _____

Personal Physician _____

Phone Number _____

Insurance Carrier _____

Policy Number _____

Preferred Hospital _____