



CONNECTICUT LYNX

ELITE LACROSSE PROGRAM

MEDICAL /WAIVER FORM

(Please complete and hand-in to your coach)

Name _____

Phone _____

Family Physician _____

Physician's Phone _____

Medical/Accident Insurance Company _____

Policy# _____

Insurance Company Address _____

Policy on the name of _____

Allergies _____

In signing this Medical/Waiver form, I release CT Lynx Lacrosse from any claims or responsibility for any injuries suffered. I knowingly assume all risks associated with participation, even if arising from the negligence of the participants or others, and assume **FULL** responsibility for my participation. I certify that I am in good physical condition and can participate in this program. I authorize the director to request medical treatment as necessary to insure my well being.

Parent/Guardian Signature _____

Date _____