Skyline Spartans Lacrosse Club Player Information and Medical Release

Experienced Player: Yes / No				
Last Name	First Name	Birth Date	Height	Weight
Street Address		Best Email(s)		
City, State, Zip		Grade ('13)	School	
Father or Guardian	Day Phone		Evening Phone	
Mother or Guardian	Day Phone		Evening Phone	
Other Emergency Contact & Relationship	Day Phone		Evening Phone	
Medical Insurance Company	Policy #			
Name of Family Physician	Phone #			

PARENT OR GUARDIAN AUTORIZATION TO PARTICIPATE

I/We, the parent(s) or guardian(s) of the above named applicant to Skyline Spartans Lacrosse Club (SSLC), hereby give my/our approval to said applicant's participation in any and all SSLC activities during the current season. I/We certify that the applicant has had a physical examination by a physician and has been cleared to participate in an aerobically intensive contact sport. I/We assume all risks and hazards incident in such participation, including transportation to and from the activities; and I/We do hereby waive, release, absolve, indemnify and hold harmless the SSLC, its board, volunteers, sponsors, supervisors, participants and any person transporting the applicant, except to the amount covered by accident or liability insurance. I/We will furnish a certified birth certificate of the applicant upon request of SSLC. I/We agree to be financially responsible for any SSLC equipment issued to the applicant other than normal wear and tear or breakage that may occur in practices and games. I/We certify, that to the best of my knowledge, all of the above information is accurate and correct and that any false information may be cause to disqualify the applicant.

INSURANCE DISCLOSURE

The medical expense benefit of the Skyline Spartans Lacrosse Club insurance coverage (through U.S. Lacrosse) is an excess type benefit that picks up where other coverage that you may have leaves off. If you have any other individual, blanket or group insurance coverage which provides benefits or services for, or by reason of, medical or dental care or treatment, then this plan will pay (to policy limits) only the medical expenses not provided or reimbursable under or other coverage.

EMERGENCY MEDICAL RELEASE

I/We the parents or guardians of the applicant, give my/our permission for any emergency treatment by any qualified individual, necessary either on the practice fields or game fields. I/We authorize any hospital and or physician to perform emergency treatment for any injuries resulting from any authorized Skyline Lacrosse Club function, including transportation to and from said function. I/we understand that any player requiring medical treatment for an injury regardless of how the injury was sustained will require doctor's written clearance to return to active Club play. This release expires on

December 31 of the year following this application

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Team Photography and Videography

I/We the parents or guardians of the applicant understand that all games, tournaments, special team events and practices may be photographed or videotaped and give Skyline Spartans Lacrosse Club My/Our permission to use photos and videos taken during Skyline Spartans Lacrosse Club events and player names for team informational, educational and promotional use including publication in local, regional and national media. These photos and videos will only be used by Skyline Spartans Lacrosse Club and will not be used to promote or endorse any other organization, product or service without my express permission.

Parent or Guardian Name (please print), Relationship, Signature and Date

Name	Relationship	Signature	Date