

POOLESVILLE ATHLETIC ASSOCIATION
WAIVER AND CONSENT FOR MEDICAL TREATMENT

LAST NAME _____ FIRST _____

ADDRESS _____ CITY _____ ZIP _____

DOB _____ WEIGHT _____

HOME PHONE _____

PARENT/GUARDIAN NAME _____ CELL _____

PARENT/GUARDIAN NAME _____ CELL _____

Name of medical insurance company _____ Policy# _____

Physician's name _____ Phone _____

Hospital preference _____ Date of last Tetanus shot _____

Emergency contact if parents can't be reached _____

Phone _____ Relationship to participant _____

Does your child have any allergies? YES OR NO? If yes, please circle below or list them.

Peanut Bee Stings Pollen/tree/grass/etc. Tree Nut

Food (Please specify below) Drug (Please specify below) Other (Please specify below)

Does your child have Asthma? YES OR NO? Has your child ever had a concussion? YES OR NO? WHEN?

Please note additional medical information and symptoms: _____

As a parent or legal guardian of _____, I hereby grant permission for my child to participate in Lacrosse sponsored by Poolesville Athletic Association. Like all athletics, accidents may occur. I consent to emergency medical treatment approved by the coach or other adult escort. I have listed all allergies, special medication needs or physical medical problems/concerns. By signing this form I accept all financial and medical responsibilities for my child.

The undersigned (personally and on behalf of the participant) covenants not to sue, and releases, waives, discharges PAA, it's coaches, volunteers, other participants, officials, from any and all loss or damage, and any claim or demands for the same on account of any injury, whether or not caused by the negligence of any such person. I further release such person from any claim whatsoever on account of emergency first aid, treatment or service rendered during participation in lacrosse.

I have also received and reviewed the Parent's Fact Sheet on Concussions. Please see page 2.

Parent/Guardian Signature _____ Print _____ Date _____