

Indiana Elite FC Medical Waiver



Player Information:

Last Name: _____ First Name: _____

Street Address: _____ City: _____ Zip: _____

Phone: _____ Gender _____ DOB _____

Email address: _____

Parent Contact Information:

Father: _____ Phone: _____

Mother: _____ Phone: _____

Emergency Contact Information:

Name _____ Phone _____

Name _____ Phone _____

Allergie: _____

Other Medical Conditions _____

Physician _____ Phone _____

Please read this form carefully and be aware in registering your minor child/ward for participation in club event(s), such as, but not limited to, clinics, tryouts, practices, games, and tournaments, you will be waiving and releasing all claims for injuries you or your minor child/ward might sustain arising out of the event(s).

I recognize and acknowledge that there are certain risks of physical injury to participation in the events(s) and I agree to assume the full responsibility for any injuries, including death, damage or loss, regardless of severity, which I or my minor child/ward may sustain as a result of participating in any and all activities connected with or associated with such event(s).

I do hereby agree to indemnify and hold harmless the Indiana Elite FC and its officers, directors, agents, volunteers, and employees from any and all claims resulting from injuries, including death, damages and losses, sustained by me or my minor child/ward, arising out of, connected with, or in any way associated with the activities of the event(s). I understand and acknowledge that there is no assurance that my child/ward or dependent will be selected as a member of the Indiana Elite FC Club.

As the parent/legal guardian, 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.

Print Name _____ Signature _____ Date _____