

**2019 Indiana Field Hockey Camps LLC  
Player Medical Release Form**

Player's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**EMERGENCY INFORMATION**

Parent/Guardian Name: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

**In an emergency, when parents cannot be reached, please contact:**

Name: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Name: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Allergies: \_\_\_\_\_ Medications: \_\_\_\_\_

Other Medical Conditions: \_\_\_\_\_

Player's Physician: \_\_\_\_\_ Office #: \_\_\_\_\_

Medical and/or Hospital Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**IMMUNIZATION INFORMATION**

State/Territory in which player resides: \_\_\_\_\_

Is this player exempt from any immunizations? \_\_\_\_\_; if yes, please list them: \_\_\_\_\_

**PARENT/GUARIDAN MEDICAL RELEASE**

I certify that my daughter has received a physical examination by a licensed medical doctor and has been found physically capable of participating in the sport of field hockey. I have provided written notice, which is submitted in conjunction with this release and attached hereto, setting forth any specific issue, condition, or ailment, in addition to what is specified above, that my child has or that may impact my child's participation in the Activity. I give permission for any medical attention necessary to be administered to my child, in the event of accident, injury, sickness, etc. under the direction of either of the emergency contact person(s) designated above, until I may be contacted. If neither of the person(s) above can be contacted, I give permission for treatment of my child to be determined by the appropriate health care professional who is present. I give my consent to have an athletic trainer and/or licensed medical doctor or dentist provide my daughter with medical assistance and/or treatment and agree to be financially responsible for the reasonable cost of any such assistance and/or treatment. I understand and accept that the risk of injury is possible while playing the sport of field hockey. I authorize the Director(s) to act for me according to their best judgment in any emergency requiring immediate medical attention.

\_\_\_\_\_  
Printed Name of Parent/Legal Guardian

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date