HARRISONBURG HORNETS BASKETBALL ACADEMY

MEDICAL RELEASE FORM

NAME: _____Date of Birth: _____ AGE: _____

PARENTS: _____

ADDRESS: _____

E-MAIL ADDRESS: Player:_____ Parent:_____

TELEPHONE NUMBER/NUMBERS: _____

SCHOOL: _____ GRADE: _____

MEDICAL INFORMATION

In Case of Emergency Call: Name: _____ Phone: _____

Doctors Name: _____ Doctors Phone #: _____

Insurance Carrier: _____Policy I.D.: _____

Any chronic medical conditions?_____ If so, please describe on the back of this form.

Any allergies to medication? Yes _____ No _____ If yes, what medication? _____

Any food, environmental or insect allergies? _____

If yes, what is the reaction? _____

Does your child carry an inhaler, epi-pen or other treatment with them (please describe)?

_____

Consent for Medical Treatment

As a Parent or Legal Guardian of the Registrant, a minor, I hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Dentistry. This care may be given under whatever conditions are necessary to preserve the life limb or well-being of my dependent.

Parent of Guardian's Signature: _____ Date: _____

General Consent

I, the Parent of the registrant, a minor, agree that I and the registrant will abide by the rules of the Harrisonburg Hornets and AAU. Recognizing the possibility of physical injury associated with the sport and in consideration of Harrisonburg Hornets Basketball Academy, it's sponsors and it's volunteers, I hereby release, discharge, and/or otherwise indemnify all those associated with this endeavor including the owners of the gyms and the facilities utilized for this program, against any claim by or on behalf of the player as a result of Participation in this Program.

Parent of Guardian's Signature: _____ Date: _____