

*****Please fill this form out completely, sign it and return it to our office via the Fax number below or bring to registration.**

FAX Number: (410) 293-5526

MEDICAL INFORMATION SHEET

Applicant's Name _____
(Please Print)

Medical Treatment Authorization

I/We, being the legal guardians of the above applicant, authorize Navy Women's Lacrosse Rivalry Challenge and its agents permission to request medical treatment as necessary to insure the well being of the applicant.

(Parent or Guardian Signature) (Date)

Insurance

Coverage for accidental injury is required by all participants. Please complete the health care information below.

Health Insurance Carrier: _____

Policy Number: _____

I approve of my child's attendance at the Navy Women's Lacrosse Rivalry Challenge and certify that she is in good health and able to participate in the program activities. I (am/am not) attaching a statement explaining special physical limitation and/or required medication. Please indicate if your child suffers from allergies, asthma, diabetes, restricted activities, etc. In further consideration of the Navy Women's Lacrosse Rivalry Challenge accepting this application, I/we hereby agree to save and indemnify and keep harmless the Navy Women's Lacrosse Rivalry Challenge, its agents, sponsors and employees against any and all liability, claims, judgments or demands for damages arising as a result of injuries sustained by the applicant during or as a result of any course given the applicant of the Navy Women's Lacrosse Rivalry Challenge.

(Parent or Guardian Signature) (Date)

(Emergency Contact) (Phone #)