CT ANGELS Softball

MEDICAL TREATMENT FORM

Name of Player: Phone:
Address:

Date of Birth:

Emergency Contact Phone: Name:

Medical Information: Please include any medical problems that the coaches should be made aware of to ensure the safety of your child. All information is confidential.

_____

_____

I/we assume the responsibility for notifying a member of the coaching staff of CT ANGELS of any change in my/our daughter's health both before and during participation in any sports activity

PHYSICIAN'S NAME:

Phone

Liability Waiver

I/we parents/guardians of the above named player, hereby give my/our approval to participate in any and all team activities. I/we assume all risks and hazards incidental to such participation, including transportation to and from activities; and I/we do hereby waive, release, absolve, indemnify and agree to hold harmless the team and its officials and sponsors for any claim arising out of an injury to my/our daughter, whether the result of negligence or for any other cause.

Parent/Guardian _____

MEDICAL TREATMENT AUTHORITY

Every effort will be made to notify parents/guardians in case of an injury to your daughter. As the parent(s)/legal guardian of the above named player, I/we authorize the coaching staff of CT ANGELS to request medical treatment as necessary to ensure the well-being of the player if the parents cannot be reached or arrive on the scene immediately.

INSURANCE CARRIER

POLICY#

Parent's Signature _____ Date_____