

VOLUNTARY RELEASE AND MEDICAL CONSENT FORM FOR INTERCOLLEGIATE ATHLETIC TRYOUTS

ATHLETE NAME_____ **SPORT**_____

I understand that the University's professional staff may provide treatment regarding routine first aid, major emergencies or medical trauma and may refer the athlete to an appropriate physician/medical personnel for further treatment. I hereby authorize consent to any X-ray, examination, anesthetic, medical or surgical diagnosis or treatment, or hospital care, which is deemed necessary and rendered under the guidance or special supervision of the physician.

Being fully aware of the hazards and possible consequences involved in treatment of the above described routine and major emergency conditions, I being legally competent to give consent, hereby consent to such treatment and hold ERAU, their employees and agents, free and harmless from any claims, demands, suits, or damages from any injury or complications whatever which may result from such treatment.

All medical expenses incurred due to my participation in _____ tryouts are understood to be my responsibility and I hereby give authorization to provide such insurance information as necessary, should I incur an injury that requires medical attention. I do hereby declare and represent that in making, executing, and tendering this Voluntary Release and Medical Consent Form for Try-outs, I understand and acknowledge the risks involved in my participation in the described activities, and that I have read this statement, understand its contents, and executed it of my free will and choice, and do so to benefit the best interest of myself.

In witness thereof, I have executed this document this _____ day of _____, 20_____.

Signature of Participant _____

Signature of Parent/Guardian _____
(for participant under age 18)

Witnesses:_____ _____
(Signature) (Date)

EMERGENCY INFORMATION

(PLEASE PRINT ALL INFORMATION)

NAME: _____ DATE: _____

SS#: _____-_____-_____ DOB: _____ SPORT: _____

EMERGENCY CONTACT: _____

EMERGENCY PHONE: _____

KNOWN HEALTH / MEDICAL PROBLEMS: _____

KNOWN ALLERGIES (MED, FOOD, BITES): _____

HEALTH INSURANCE YES / NO

HEALTH INSURANCE NAME: _____

HEALTH INSURANCE POLICY #: _____

HEALTH INSURANCE GROUP #: _____