Doddridge County Parks & Rec. Commission

PARENT/GUARDIAN CONSENT AND PLAYER MEDICAL RELEASE FORM
Return completed form with Payment to DC Park or mail to
Doddridge County Parks, P.O. Box 426, West Union, WV 26456

Player's Name: _____ Age: _____ Grade: _____ Date of Birth: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Name:
_____ Home Phone: _____ Cell Phone: _____

EMAIL: (list two if needed) _____

SPORT REGISTERING (please circle) **Soccer** All Ages **Rookie Rugby** Ages (6-14) **Basketball** All Ages

FEE: $45 for first child _____ $25 each additional child _____

T-shirt size: (circle one) **Youth**: YS YM YL **Adult**: S M L XL XXL

EMERGENCY INFORMATION

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

Name: _____ Home Phone: _____ Cell Phone: _____

Name: _____ Home Phone: _____ Cell Phone: _____

Allergies: _____

Other Medical Conditions: _____

Player's Physician:_____Office Phone: _____

Medical and/or Hospital Insurance Company:_____Phone: _____

Policy Holder:_____Policy #:_____Group #:_____

PLEASE COPY BOTH SIDES OF YOUR HEALTH INSURANCE CARD AND ATTACH TO THIS FORM
PARENT/GUARDIAN CONSENT AND MEDICAL RELEASE

Recognizing the possibility of injury or illness, and in consideration for DCPRC and members of DCPRC accepting my son/daughter as a player in the programs and activities of DCPRC and its members (the "Programs"), I consent to my son/daughter participating in the Programs. Further, I hereby release, discharge, and otherwise indemnify DCPRC, its member organizations and sponsors, their employees, associated personnel, and volunteers, including the owner of fields and facilities utilized for the Programs, against any claim by or on behalf of my player son/daughter as a result of my son's/daughter's participation in the Programs and/or being transported to or from the Programs. I hereby authorize the transportation of my son/daughter to or from the Programs.

My player son/daughter has received a physical examination by a licensed medical doctor and has been found physically capable of participating in the sport of soccer. 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 Programs. I give my consent to have an athletic trainer and/or licensed medical doctor or dentist provide my son/daughter with medical assistance and/or treatment and agree to be financially responsible for the reasonable cost of any such assistance and/or treatment.

Date_____ Amount Paid_____ Check #_____ Cash_____

CC#_____ EXP Date _____ Security #_____ZIP #_____

_____ _____
Signature of Parent/Guardian **Cell #** **Date**

Staff Initials_____