

**ASTON ATHLETIC ASSOCIATION  
MEDICAL INFORMATION & LIABILITY RELEASE**

**Please print and complete all areas:**

Player's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**EMERGENCY TELEPHONE NUMBERS:**

Phone numbers where coaches can reach a parent or an emergency contact for the child named above during scheduled events.

Parent/Legal Guardian Name: \_\_\_\_\_

Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Cell: \_\_\_\_\_

**MEDICAL INSURANCE CARRIER**

Parent/Legal Guardian's Insurance Group Name \_\_\_\_\_

Insurance Group Number \_\_\_\_\_

**MEDICAL INFORMATION**

Family Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Allergies, conditions, dietary restriction, special needs, medical concerns of which we should be aware:

Food: \_\_\_\_\_ Drug: \_\_\_\_\_

Animal: \_\_\_\_\_ Other: \_\_\_\_\_

My child requires the following medicine: \_\_\_\_\_

Frequency: \_\_\_\_\_

My child has permission to be given Tylenol or Ibuprofen if they request it: \_\_\_ Yes / \_\_\_ No

In case of Medical Emergency I understand that, in the event medical treatment is required, every effort will be made to contact me or the emergency contact person. However if I cannot be reached, I give permission to the staff to secure the services of a licensed physician to provide the care necessary, including hospitalization, anesthesia, injection, or surgery for my child's well-being. I hereby agree to indemnify and hold harmless Aston Lacrosse, Aston Athletic Association, and its officers, employees, and volunteer staff from any liability.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

Date \_\_\_\_\_

THIS FORM MUST BE RETURNED FOR REGISTRATION TO BE COMPLETED.