Venom Sports
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914.923.5258 x160 / 914.923.5259 (fax)
Venom@VenomSports.net / www.VenomSports.net

MEDICAL & CONSENT FORM

Athlete's Information Sport:_____

Name:_____

Address:_____City: _____State: _____ Zip:_____

Telephone _____Birth Date: _____Male _____Female:_____

Medical Information

Doctor's Name:_____Doctor's Phone#:_____

Health Insurance Carrier:_____Policy #:_____

Any Medical restrictions/problems? _____

Any Medical restrictions/problems?_____

Any allergies or medications being taken? _____

Consent for Medical Treatment (Minor)

As the parent or legal guardian of the above mentioned player, I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of my dependant. Please accept one of the parties named below as having received my permission to authorize medical treatment for my child in my absence:

Authorized Contacts for Medical Treatment:

1._____ Phone:_____

2._____ Phone:_____

I, the parent/guardian of the registrant, a minor, agree that I will abide by the rules of Venom Sports, its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with playing competitive sports, I hereby release, discharge and/or otherwise indemnify Venom Sports, its affiliated organizations and sponsors, their employees, volunteers and associated personnel, including the owners of the facilities utilized for the programs, against any claim by or on behalf of the registrant as a result of the registrant's participation in the programs and/or being transported to or from the same, which transportation I hereby authorize.

Name:_____ Signature:_____

Parent/Legal Guardian (PLEASE PRINT)

Notarized: _____ Date:_____