



# Ultimate Frisbee® Club

## Informed Consent/Waiver

ALL items must be completed and all signatures are required. No forms accepted without completion of all items.

Participant's name (print) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Recognizing the possibility of physical injury associated with the sport of Ultimate Frisbee®, I hereby release, discharge and or otherwise indemnify the SLP Ultimate Frisbee® Club, Community Education and ISD 16 School Board and its representatives, successors, and assigns, its affiliate associations, member teams, event hosts and each of them and their directors, officers, employees, operators, trustees, members and agents against and from any and all claims, expenses, costs, damages, loss, accidents, fines, judgments, awards, liabilities and causes of action as a result of the registrant's participation in the sport of lacrosse. I assume all risks associated with participation in this sport, including but not limited to falls, contact with other participants, the effects of weather, traffic, and other reasonable risk conditions associated with the sport of Ultimate Frisbee®. **All such risks to my child are known and understood by me.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Player Signature \_\_\_\_\_ Date \_\_\_\_\_

### Consent for Medical Treatment:

As a parent or legal guardian of the player listed above, I hereby give my consent to Spring Lake Park Ultimate Frisbee® Club, Community Education, and ISD 16 to provide emergency medical treatment of an injury or illness of my child if qualified medical or dental personnel consider treatment necessary and perform the treatment. This authorization is granted only if I cannot be reached and a reasonable effort has been made to do so. I provide this contact information to the best of my knowledge.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Name (print) \_\_\_\_\_

Phones: Cell \_\_\_\_\_ Work \_\_\_\_\_ Home \_\_\_\_\_

Health Care Provider \_\_\_\_\_ Policy Number \_\_\_\_\_

Physician Name \_\_\_\_\_ Dentist Name \_\_\_\_\_

Physician Phone \_\_\_\_\_ Dentist Phone \_\_\_\_\_

Pre-existing medical conditions. List any and all medications.

*Previous Injuries:*

*Allergies or chronic illness:*

*Special Needs:*

*Medications:*

In case of emergency, contact: \_\_\_\_\_ Phone \_\_\_\_\_  
someone OTHER than parent listed above

Relationship to child \_\_\_\_\_