



Brookfield Central Jr. Lancer Girls
Basketball Club 2015 – 2016

Medical Release Form

This must be completed – legibly – and signed in all areas by the parent or guardian of each Brookfield Central Jr. Lancers Girls Basketball participant. I understand and agree that this document will be kept in the possession of the coaching staff and that reasonable care will be used to keep this information confidential. By signing below on behalf of my participant, I affirm having read and agreed to the terms and conditions described in this document.

First Name Last Name Birth Date Age Male Female

Primary Contact: Parent or Guardian

Name: Address:
Primary Phone: City, State & Zip:
Alternate Phone:

Secondary Contact: Parent/Guardian Other

Name:
Primary Phone: Alternate Phone:

Primary Insurance Co Primary Group/Policy #
Family Physician Name Physician Phone#

Please voluntarily disclose any medical conditions of which we should be aware:

And medications currently being taken:

Any allergies:

If none, please write 'none.'

Participant, has my permission to participate in training, competition, events, activities and travel as part of the club program. I approve of the coaches who will be in charge of the team. I recognize that the coaches are serving to the best of their ability. I certify that the participant has full medical insurance with the company listed above. If uninsured, I understand that the Brookfield Central Jr. Lancers Girls Basketball does not provide medical insurance for its participants, and I will be held personally responsible for any medical expenses incurred. Although this information will be kept confidential throughout the season, I agree to allow the authorized coaches to release this information in the event of a medical emergency to a third party medical provider. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

Parent/Guardian signature: Date:
Relationship to Participant:

If, during the course of my daughter's activities in basketball, she/he should become ill or sustain an injury, I hereby authorize you to obtain emergency medical/dental care. I will assume financial responsibility for the bills incurred.

Signature: Date:
Parent/Guardian

I do not authorize emergency medical/dental care for my daughter.

Signature: Date:
Parent/Guardian