

CHS LACROSSE YOUTH CLINIC

February 27th, March 6th, and 13th, 2010
Registration, Permission and Emergency Form

Clackamas High School Lacrosse Team is affiliated by Clackamas High School in name only as a club sport. Clackamas High School is not sponsoring this clinic and therefore carries no liability for any injuries which may happen during the clinic.

Athlete

Name: _____

Grade: Elementary _____ Middle School _____

Position: _____

Date of Birth: _____ Current age: _____

Address: _____ City _____, Oregon

Guardian's name _____ Home ph # _____ Work or cell# _____

Name of current school _____

Have you ever played Lacrosse before? Yes No If yes, how many years? _____

Would you consider yourself (circle one) beginner played some skilled

Injury and Risk and Parent Permission

My son/daughter has permission to participate in the CHS Lacrosse Youth Clinic. Lacrosse is inherently dangerous. Accidents can happen and risks of serious injury do exist. Your signature indicates that you have completed all of the information accurately, that you have been advised that there is a risk of injury that could occur. By signing this form, you give permission for your son/daughter to participate in the CHS Lacrosse Youth Clinic, and will hold coaches, officials, volunteers, parents, students, and all others associated with the CHS Lacrosse Youth Clinic harmless for any and all costs, claims, awards, judgments, and/or attorney fees for damages arising out of or in any way resulting from or brought by voluntary participation in the CHS Lacrosse Youth Clinic. You also agree to pay for all medical care and carry adequate medical insurance in order to participate in the CHS Lacrosse Youth Clinic.

Parent/Guardian Signature: _____ Date: _____

Are there any special considerations of your child we should be aware of
of _____

Medical Emergency Information

Allergies to medications or others: _____

Any other health or medical problems _____

Medications _____

Person to call in case of emergency: _____ phone # _____

Alternate _____ phone# _____

We will attempt to call parents first please list others for emergency contact.

Family

Doctor: _____ Phone: _____

CHS LACROSSE YOUTH CLINIC Medical Emergency Authorization

Name of Athlete _____

As a parent or legal guardian, I authorize a qualified physician to examine the above-named athlete and in the event of injury or sudden illness, to administer care and to arrange for any consultation he/she deems necessary to ensure proper care of any injury or illness. Every effort will be made to contact Parent/Guardian to explain the nature of the problem prior to any involved treatment.

I understand that I will assume full responsibility for payment of any services rendered.

Parent/ Guardian Signature: _____ Date: _____

Make Checks Payable to: CHS Lacrosse Club