Lakeview JO Volleyball
Consent for Medical Treatment and Waiver Form

Player's Full Name: ____

DOB:____

Family Doctor: ____

Do you have an Inhaler:____

Current Medications:____

Any medical conditions you want coaches to be aware of:__________________________________

Emergency Contact Name (nonparent):____

Emergency Contact Number(nonparent):____

Parent(s) number(s):____

I, the undersigned, as parent/guardian of the minor child, give my permission for the player named above to play on a Lakeview JO Volleyball team. I acknowledge that playing on a JO team could lead to injuries because of the factors inherent in this type of activity. I accept the responsibility for any medical treatment and its expenses. I understand that the people associated with the Lakeview JO board, coaches, parents, and financial supporters are exempt from any liability or blame for any and all injuries, accidents, and/or damages that might occur during the ordinary course of the activity.

I authorize and consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment to be rendered to my minor child under the general physician or surgeon licensed to practice in the healing arts, when the need for such treatment is immediate and when efforts to contact us are unsuccessful.

Parent Name (printed) ____________________________________

Parent Signature____

Date:_______________