

**Lightning Athletics
Medical Release Form 2008-2009**

Player _____

Address _____

City _____ State _____ Zip _____

Emergency Phone: H: _____ W: _____ Cell: _____

Other Emergency Contact:
Name _____ Phone _____

I hereby give my permission for _____ to participate in the LIGHTNING Athletics program. I understand that, in the event medical treatment is required, every effort will be made to contact me. If I cannot be reached, I give my permission to the sponsor to give first aid to my child and/or to secure the service of a licensed medical care provider to provide the care necessary, including anesthesia, for my child's well being. I also understand that all medical expenses will be my responsibility, and that no member of the Lightning Athletic organization will be held responsible for medical expenses.

Insurance Co: _____ Policy # _____

Date of last tetanus shot: _____

Please list any medical allergies, medications being taken, medical problems, or other pertinent information:

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____

Date: _____