

PALO ALTO GIRLS SOFTBALL

2015 PLAYER MEDICAL RELEASE



YOU MUST COMPLETE, SIGN, AND RETURN THIS MEDICAL RELEASE OR YOUR DAUGHTER WILL NOT BE ALLOWED TO PRACTICE OR PLAY. THIS IS FOR HER PROTECTION.

PALO ALTO GIRLS SOFTBALL
P.O. Box 60027 ● Palo Alto, CA 940306
www.paloaltogirlssoftball.org
650.209.0454.

PLAYER: LAST NAME: _____
FIRST NAME: _____
DATE OF BIRTH: _____
SCHOOL: _____ GRADE _____

PARENT(S) NAME: _____ email: _____
Telephone : Home: _____ cell: _____
NAME: _____ email: _____
Telephone : Home: _____ cell: _____
ADDRESS: City/State/Zip Code: _____

MEDICAL:
PHYSICIAN: _____
Telephone: _____
Medical Policy Name: _____
Medical Insurance Policy Number: _____
Medical Conditions: _____

MEDICAL RELEASE / LIABILITY WAIVER:

As the Parent/Guardian (s) of the player named herein, I (we) acknowledge that participation in Palo Alto Girls Softball, as in any sport, may result in injury. I / we hereby release Palo Alto Girls Softball (PAGS), its members, agents, officers, coaches, managers, and players from all liability or responsibility for any claim, damage, or legal action on behalf of the player or the player's parents, their or personal representative arising from any injury the player may sustain while participating in PAGS softball. I / we hereby authorize, in the event of injury, any representative of PAGS to obtain whatever medical attention is deemed necessary for my / our daughter/ward. I / we hereby authorize any qualified medical practitioner to render such emergency medical treatment that he/she deems necessary for my / our daughter/ward. I / we hereby state that my daughter/ward is in good health and is physically able to play girls softball.

Signature: _____ date: _____

Print Name: _____
