

Palatine Celtic Soccer Club Travel Tryouts

Emergency Release Form

PLEASE PRINT ALL INFORMATION

FOR OFFICE USE ONLY
Tryout Number
Age trying out for
Gender

Participant's Last Name First Name Home Phone

Gender Birthdate Age as of 9/1/10 Grade in Fall

Last Name (head of household) First Name

Address City State Zip

Returning player New player Please check if new address or phone number

Family Contact Email Address

Parent Contact Data
Name
Work Phone
Cell Phone
Add. Parent Contact Data
Name
Work Phone
Cell Phone

This section MUST BE completed for ALL Soccer participants.

By their very nature, many Park District programs involve body contact, substantial physical exertion, emotional stress, and/or use of equipment which represents a certain risk. It is recommended that you check with your physician prior to participating in Palatine Park District activities. Palatine Park District does not provide insurance protection for participants in Park District activities. Please read the following information carefully and be aware that in registering yourself or your minor child/ward for participation in the above program(s), you will be waiving and releasing all claims for injuries you or your child/ward might sustain arising out of the above program(s). I give my child permission to participate in this program, trip, or activity and hereby waive, release and forever discharge any and all claims against the Palatine Park District or its commissioners, employees, or volunteers for damages and/or injuries to the registrant, which may arise from participation in Palatine Park District programs. EMERGENCY TREATMENT: A minor may not be treated, even in an emergency, except when, in the opinion of the attending physician, a life is in the balance. Written consent is required for all treatment given in any hospital emergency room/center. Consent of a parent or legal guardian is necessary for unmarried minors, under 18, except in cases of extreme emergencies. TO WHOM IT MAY CONCERN: As a parent and/or legal guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the above minor in the event of a medical emergency which, in the opinion of the attending physician may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. The release form is completed and signed of my own free will with the purpose of authorizing medical treatment under emergency circumstances in my absence. Please list specific medical allergies, medicines, or other conditions on the reverse side of this form or on a separate piece of paper to be attached to this form.

Signed _____

Relationship to participant _____

Emergency Name _____

Emergency Phone _____

Please indicate if there is any medical information (asthma, diabetes, etc.)
or food allergies that the staff should be aware of _____