

Sprague Water Polo

REGISTRATION

Registration, Permission & Emergency Form

Sprague Water Polo Club is affiliated by Sprague High School in name only as a club sport. They are not sponsoring this sport and therefore carry no liability for any injuries, which may happen during the Sprague Water Polo Club season.

Section 1: INFORMATION

Athlete Name: _____
(Last) (First) (Middle Initial)

Male: Female: Grade: 9 10 11 12 Date of Birth: _____

Address: _____

Mother's Name: _____

Home Phone: _____ Business Phone: _____

Father's Name: _____

Home Phone: _____ Business Phone: _____

E-mail Address: _____ Name of current school: _____

USA Water Polo # (if applicable): _____

Section 2: INJURY RISK & PARENT PERMISSION

My son / daughter has permission to participate in Sprague Water Polo Club. Water polo 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 Sprague Water Polo Club, and will hold coaches, officials, volunteers, parents, students, pool facilities, Sprague High School and all others affiliated with Sprague Water Polo 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 Sprague Water Polo Club. You also agree to pay for all medical care and carry adequate medical insurance in order to participate in the Sprague Water Polo Club.

Parent / Guardian Signature: _____ Date: _____

Section 3: MEDICAL EMERGENCY INFORMATION

Athlete Name: _____ Date of Birth: _____

Home Address: _____

Person to call in case of injury: _____

Relationship: _____ Phone Number: _____

Secondary person to call in case of injury: _____

Relationship: _____ Phone Number: _____

Other Phone Numbers: _____

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Medications in Use: _____

Medications allergic to: _____

Family Doctor: _____ Phone Number: _____

Doctor's Office Address: _____

Other allergies and medical conditions: _____

Section 4: MEDICAL EMERGENCY AUTHORIZATION

Name of Athlete: _____

(Last)

(First)

(Middle Initial)

As a parent of 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: _____

Section 5: PHYSICAL EXAMINATION

I understand that my son / daughter must undergo a thorough medical examination and be approved for interscholastic athletic competition by a medical authority licensed to perform a physical examination. My signature below indicates that my son / daughter has received this examination within the guidelines of Sprague High School for athletic programs with the following assessment:

Full Participation: Limited Participation:

Please describe limitations and/or restrictions: _____

Parent / Guardian Signature: _____ Date: _____