METRO HEAT VOLLEYBALL CLUB WAIVER and Release Form

As the parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (“child”). I do for both of

child’s parents, for child and childs heirs and successors, release Rosie DeLaVega, Metro Heat Volleyball Club, Christ Lutheran Church, Arborlawn United Methodist Church, Southwestern Baptist Theological Seminary, Bethel Baptist Church, South Hills High School and Game On and any of its agents, volunteers or representatives from any and all claims arising out of or in connection with child’s participation in this league. I understand and agree that athletics, physical training and competition can be dangerous and can lead to serious injury or possibly death regardless of how careful any person, firm or facility might be. Further, I give permission to Camp Directors to treat my child or arrange for medical care or treatment for my child in

any situation deemed reasonably necessary. If circumstances permit, CAMP STAFF shall attempt to communicate first via telephone with the following emergency contacts for child.

**Emergency Contact Information**

Name and relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the event neither emergency contact can be reached or if the urgency of the situation requires immediate attention without prior telephone contact, CAMP STAFF may arrange

for medical treatment for the child at the expense of the parent or legal guardian signing

this form.

**Health Insurance information for child is as follows**

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy number \_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_ St \_\_\_ Zip \_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To seek appropriate medical care of treatment of child, please disclose the following

Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please specify, enter “none”)

Heart disease or other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please specify, enter “none”)

Any other conditions, symptoms or disability which would or might affect medical

care or treatment or participation in this activity

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Parent or legal guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_