

Wheaton College Field Hockey Indoor Play Day Insurance and Waiver Form

(This form must be filled out and turned in before you participate.)

Participant's Name _____ Age _____

Address _____

School Name Worcester County United Field Hockey

Number of years playing field hockey _____ Position(s) _____

Allergies _____

Medical Conditions _____

Emergency Contact _____ **Phone** _____

Insurance Company _____

Policy Holder's Name _____

Policy Number _____

I, the parent (guardian), give permission for the above named participant to receive emergency medical or surgical treatment and hospitalization if necessary. I understand that there is a risk of injury to the named participant as a result of clinic activities, and knowingly and voluntarily assume all risk of such injury. I understand that every attempt will be made to contact me or the emergency contact before action is taking. I hereby waive and release Wheaton College, the Staff, and clinicians, from any liability for any injury or illness incurred while at the clinic. I will be financially responsible for any medical attention needed during the clinic or resulting from an injury received at the clinic. My medical insurance shall be the insurance coverage for any medical treatment.

Parent (Guardian) Signature

Date