MEDICAL RELEASE FORM

NAME:

DOB:

AGE:

Allergies:

Parent/Guardians Name:

Parent/Guardians Phone Number:

Contact Person in Case of an Emergency:

Contact Person Relationship:

Please attach an updated copy of your insurance card.

I _____ understand and acknowledge the risks involved in the physical activity I will be taking part in during tryouts and recruiting clinics.

Coach Ryan Salami

P.O BOX 479

STATE UNIVERSITY, AR 72467