# CONNECTICUT LYNX

## ELITE LACROSSE PROGRAM

MEDICAL /WAIVER FORM

(Please complete and hand-in to your coach)

Name_______________________________________________

Phone______________________

Family Physician_________________________________________

Physician's Phone_______________________________________

Medical/Accident Insurance Company______________________________________________

Policy#_______________________________________________

Insurance Company Address_______________________________________________

Policy on the name of____________________________________

Allergies______________________________________________

In signing this Medical/Waiver form, I release CT Lynx Lacrosse from any claims or responsibility for any injuries suffered. I knowingly assume all risks associated with participation, even if arising from the negligence of the participants or others, and assume **FULL** responsibility for my participation. I certify that I am in good physical condition and can participate in this program. I authorize the director to request medical treatment as necessary to insure my well being.

Parent/Guardian Signature________________________________

Date_____________________