TEAM 203 LACROSSE CLUB
Assumption of Risk/Release/and Grant for Medical Treatment

Players will not be able to participate without a signed form.

Participant's Name:_____
(Please Print Clearly)

I, _____, am the parent/legal-guardian of, _____ ("Player") who has my permission to participate in the lacrosse Clinics, Practices or Tournaments run by the TEAM 203 LACROSSE CLUB. I know that lacrosse is a contact sport that is inherently dangerous and involves risks of injury or even death. Furthermore, I acknowledge that there are ever-present risks in life generally and that during my child's involvement in the TEAM 203 LACROSSE CLUB, playing in a game, practicing, or otherwise engaged with the TEAM 203 LACROSSE CLUB Tournament. I knowingly and voluntarily assume these risks, and hereby release and hold harmless TEAM 203 Lacrosse CLUB, and all of its agents, representatives, and assigns, from all liability, claims, rights or causes of action which may accrue as a result of personal injury or property loss or damage sustained by player arising out of, or as a consequence of Player's participation in the TEAM 203 LACROSSE CLUB program/CT CUP Tournament.

Moreover, lacrosse tournaments in general consist of lacrosse balls flying everywhere. I as well as my family understands and assumes all risk with regards to any injuries resulting from being struck and injured by a lacrosse ball or any other object during the CT Cup Tournament.

I hereby authorize the TEAM 203 Lacrosse Club personnel and coaches to authorize the performance of emergency treatment for children who incur injury or become ill, whose parents or guardians cannot be reached through reasonable efforts under the circumstances. I can best be reached at this number:_____.

As a parent/guardian, I authorize the treatment of my child, _____, by a qualified and licensed medical professional, in the event of injury or sickness for which medical and/or surgical treatment is deemed appropriate by a qualified and licensed medical professional. This release is effective during any period of time in which my child is participating in the TEAM 203 LACROSSE CLUB. I also hereby acknowledge my full and sole responsibility for payment of fees or costs for any treatment that my child receives pursuant to this Consent.

Signature of
parent/guardian:_____Date:_____

Printed name of
parent/guardian:_____Phone:_____

Family Doctor:_____Phone:_____

*My child's U.S. Lacrosse #_____
Facts concerning the child's medical history including allergies, medications being taken, medications causing an allergic reaction, and any physical impairment or condition about which a physician should be alerted: (Elaborate on back of this form if necessary.)