

Cypress Infield Academy Medical Release Form

Player Name: _____ Age: _____
Address: _____ City: _____ Zip: _____
Parent/Guardian Name(s): _____
Home Phone: _____ Work Phone: _____
Emergency Contact: _____ Phone: _____ Relationship: _____
Child's Doctor: _____ Phone: _____
Existing Medical Coverage: _____ Plan #: _____
Known Allergies:

(include medicine, food, bee stings, etc.)

Current Medications:

(or any related information that would assist in safe treatment)

Medical Release:

I hereby permit my child to participate in the Cypress Infield Academy program. I understand and fully accept that there are risks involved in sports, and that accidents and injuries are common and are ordinary occurrences of sports. I hereby release and hold harmless Cypress Infield Academy, Cypress Infield Academy staff, designated coaches, and program officials and supervisors from all liability, and from all actions or claims that I or my child now or hereafter have for damage or injury to my child, or to any person or property, resulting from the negligence or other acts of any employees or volunteers in connection with my child's participation.

In case of a medical emergency, I hereby give permission to Cypress Infield Academy to order treatment for my child. This includes any necessary medical treatment and x-rays. Of course, I understand that an attempt will be made to reach me by phone when a diagnosis is completed. I also understand that all related medical costs are my responsibility.

Parent or Guardian Signature Date