SIOUX CITY WARRIORS
REGISTRATION AND MEDICAL RELEASE

Player Name ____________ Player Birth Date ____________ Player Grade ____________

Player Height ____________ Player Cell Phone ____________ Player Email ____________

Player Address ____________

PARENT/GUARDIAN INFORMATION

Name ____________ Cell Phone ____________ Email ____________

Name ____________ Cell Phone ____________ Email ____________

MEDICAL & EMERGENCY INFORMATION

Name ____________ Cell Phone ____________ Email ____________

Name ____________ Cell Phone ____________ Email ____________

Health Insurance Carrier ____________ Policy Number ____________

Medical Issues/Allergies/Etc.

Date of Player's Last Tetanus Shot

MEDICAL RELEASE

I hereby give my permission for ______________________ to participate in the Sioux City Warriors Athletic Program. I understand that, in the event medical treatment is required, every action will be made to contact me. If I cannot be reached, I give my permission to the sponsor to give first aid to my child and/or to secure a service of a licensed medical care provider to provide the care necessary, including anesthesia, for my child's well being. I also understand that all medical expenses will be my responsibility and that no member of the Sioux City Warriors Athletic Program will be held responsible for medical expenses.

Parent/Guardian Signature

Date