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 playing for the Connecticut Titans Lacrosse Program, Hartford County, Connecticut during all, or part, of the 2022 - 2023 calendar year. 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 Connecticut Titans, playing in a game, practicing, or otherwise engaged with in certain tournaments. I knowingly and voluntarily assume these risks, and hereby release and hold harmless Connecticut Titans 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 Connecticut Titans.

I hereby authorize the Connecticut Titans 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 Connecticut Titans season(s). 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:_____
Medical Insurance Company:_____Policy #_____
Alternate person to notify:_____Relationship:_____
Phone:_____

Family Doctor:_____Phone:_____

My child is also a member of U.S. Lacrosse: Y N (circle one) Membership #_____

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.)

Parent email address:_____Home Address_____

Signature:_____Date:_____

Parent Name:_____ Player email address:_____