ARCHDIOCESE OF MILWAUKEE

Parent's and/or Legal Guardians Risk Acknowledgement and Consent to Participate Form

Participant _____ Birth Date_____

Address

_____

1 Parent/Guardian _____

Parent/Guardian Address _____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

2) Parent/Guardian _____

Parent/Guardian Address _____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

My/our child wishes to participate in the 2017 Volleyball Camp with Coach Casey at St. Anthony on the Lake Parish. I/We realize that there are numerous risks involved in participating in the above listed volleyball camp. These risks could involve (but are not limited to): sprains, contusions, broken bones, lacerations, concussions, permanent disability, internal injuries, paralysis and possibly death. These risks could impair my/our child's future abilities to earn a living, engage in business, social, and recreational activities and to generally enjoy life. I/We have been informed about the various risks associated with our child's participation in the above listed camp and the potential injuries that may occur. I/We assume all responsibility and certify my/our child is in good physical condition and has undergone a sports physical in the past two years. Further, I/we are unaware of any medical condition that would inhibit my/our child's participation. As a condition of our child's voluntary participation in the above mentioned camp, I/we agree to accept all the previously mentioned risks as a condition of my/our child's participation. I/we hereby waive and release St. Anthony on the Lake and Coach Casey's Camps, all of its employees, instructors, and directors from any and all liability from any illness or injury my child may occur while participating in this camp.

_____ _____

Parent/Legal Guardian Date

_____ _____

Parent/Legal Guardian Date

Form 6145.2(b) Archdiocese of Milwaukee Form revised: 5-6-97 9/4/2007

Please complete page 2

ARCHDIOCESE OF MILWAUKEE

Student Athlete - Medical Information & Emergency Consent Form

Participant's Name _____

Address _____

City _____ Zip _____ Phone _____

Parent / Legal Guardian _____

Address _____

Employer _____

Home Phone _____ Work Phone _____

Other Emergency Contact Person _____ Phone

_____

MEDICAL INFORMATION:

Family Physician: _____ Phone _____

Group / Address _____

Hospital of preference: _____

Insurance Info: Subscriber: _____ Group #: _____

Policy #: _____ Company: _____

Pre-existing Medical Conditions: _____

_____

I authorize the coaching staff to provide emergency medical treatment of an injury to or illness by my child if qualified medical personnel consider treatment necessary. I further authorize any qualified, licensed physician to render medical treatment which in his or her judgment may be deemed necessary in the care of (child's name) _____

_____ ____ _____

Parent / Legal Guardian Date

_____ _____

Parent / Legal Guardian Date