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 ______________

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Medical Issues/Allergies/Etc.

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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