4LINEMANONLY LLC
FOOTBALL TRAINING PARENT PERMISSION & MEDICAL AUTHORIZATION FORM

PLEASE COMPLETE, SIGN & RETURN BEFORE TRAINING!

ATHLETE INFORMATION:

Athlete's Name (Last, First): _____

Athlete's Address: _____

City:_____ Zip Code:_____

Date of Birth (MO/DY/YEAR):_____ Age:_____

Athlete's School: _____

Athlete's Graduation Year: _____ Grade:_____

Athlete's Position:_____

GUARDIAN & EMERGENCY CONTACT INFORMATION:

Parent's Name:_____

Primary Contact Number:_____

If unable to reach parent, other authorized emergency contact:

Name:_____

Secondary Contact Number:_____

Address:_____

Relationship to Athlete:_____

Physician's Name:_____

Insurance Carrier's Name:_____

Insurance Policy Number:_____

Athlete's Medical Considerations (Pre-existing Conditions, Allergies to foods/medicines, etc.):

Note: If not applicable, please write N/A.

_____

_____

EMERGENCY DISCLOSURE & MEDICAL AUTHORIZATION:

In the event of an emergency, when a parent or guardian is unavailable, I authorize 4LINEMANONLY LLC personnel to make arrangements for my child to receive medical or hospital care, including necessary transportation, in accordance with their best judgment. I authorize the physician named above to undertake such care and treatment as is considered necessary. In the event said physician is unavailable, I authorize such care and treatment to be performed by a licensed physician or surgeon, I agree to cover all costs incurred as a result of the foregoing.

I UNDERSTAND THAT BY SIGNING BELOW I AM GIVING PERMISSION FOR MY ATHLETE TO PARTICIPATE IN THIS ACTIVITY, AND THAT MY ATHLETE AND THAT I ARE GIVING MEDICAL AUTHORIZATION.

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Parent/Guardian Signature **Date**