



Hilliard Lynx Middle School and High School Field Hockey Club
Lynx Clinic
Medical Release Form

Player Name _____

Parent Name _____

Emergency Contact:

Name _____

Phone _____

Medical Conditions: _____

Please provide information on any medical conditions that the Hilliard Lynx Field Hockey Club should be aware of including food allergies, special needs, etc.

Doctor Name and Phone #: _____

Dentist Name and Phone #: _____

Preferred Hospital: _____

RELEASE OF LIABILITY: (Read and Sign Below)

1. For One Dollar and other valuable consideration, I release the City of Hilliard, the Hilliard City Schools, its members and coaches of any liability arising out of the participation of my daughter whose name appears above.
2. The Hilliard Lynx Field Hockey Club will periodically take photographs of participants to promote our program via the website and other printed publications. By signing below you are giving the club permission to publish said photographs.
3. The undersigned understands that **refunds will not be given under any circumstances.**
4. My signature below acknowledges that I have read this document in its entirety, that I understand the terms outlined above, and that I agree to comply with all terms and rules established by the club.

Signature of Parent/Guardian: _____

Date: _____