RYF Reconstructing Youth Foundation

THIS FORM IS TO BE CARRIED TO ALL SANCTIONED COMPETITIONS & PRACTICES.

2014-2015 R.Y.F. PLAYER MEDICAL RELEASE FORM

This must be completed - legibly - and signed in all areas by both the player and his/her parent or guardian. I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential. ***By signing this form the participant affirms having read and agreed to the terms and conditions listed below.***

___________________ ____________________ ___________________ ____________ _____________

FirstName **Last Name** **Birth Date** **Age** **Gender**

Primary Contact: Parent or Guardian
Name: _______________________________________ Address: ______________________________
Primary Phone: _______________________________ City, State & Zip: ______________________
Alternate Phone: ______________________________ ______________________

Secondary Contact: Parent or Guardian or Other __________________________________
Name: _______________________________________
Primary Phone: _______________________________
Alternate Phone: ______________________________

Primary Insurance Co _______________________ Primary Group/Policy #_______________
Family Physician Name: ______________________ _______________
Physician Phone: ______________________________

Please elaborate on **<u>any medical conditions</u>** of which we should be aware:

Please list any **<u>medications</u>** currently being taken:

In the past 24 months, have you been tested, diagnosed and/or treated for a concussion: £Yes £No
If yes, provide the date (months and year), who performed the testing/diagnosing/treatment and what was the outcome:

Please list any **<u>allergies</u>**:

If None, please write None.

If, during the course of my daughter's/son's activities in Basketball, Programs, or Camps at R.Y.F., she/he should become ill or sustain an injury, I hereby authorize you to obtain emergency medical/dental care. I will assume financial responsibility for the bills incurred through my insurance company.

Signature: ____ Date:_____________________________

OR

I **do not authorize** emergency medical/dental care for my daughter/son.

Signature: ____ Date:_____________________________

Participant Signature: ______________________________Date: _______________________

(Regardless of age):

Participant, ____________________________________, has my permission to participate in programs, camps, training, competition, events, activities and travel sponsored by Reconstructing Youth Foundation (R.Y.F.) I approve of the leaders who will be in charge of this program. I recognize that the leaders are serving to the best of their ability. I certify that the participant has full medical insurance with the company listed above. I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential. I agree to allow the authorized adult team personnel to release this information in the event of a medical emergency to a third party medical provider. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

Participant Signature: ______________________________Date: _______________________

Relationship to Participant: ____