PARENT HEALTH AUTHORIZATION FOR CHILD PARTICIPATION

Student Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Health Insurance Information:

Insurance Plan:
Policy/Group#:

Please provide the following basic health information for your child:

☐ Does your child have any medical conditions that could affect his or her performance or need to be considered when planning training?

Please specify:

☐ Allergies (specify):

☐ Medications (specify):

I believe, to the best of my knowledge, the above named student to be in good health, is suffering from no illness and is able to participate in all hockey related training, which demands physical exertion and stamina. I understand that with the exception of uncomplicated basic first aid treatment for minor injury, **Old School Goal School™** will accept no responsibility for accident or illness by the student during the program. I hereby give my approval for emergency medical treatment if required.

Signature of Parent/Guardian: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.