Lady Bulldogs Volleyball, LLC.

Medical Release and Waiver Form

GUARDIAN NAME: ____ E-MAIL:______________________________
ADDRESS: ______________________________________ CITY:_______________ ST:____ ZIP:____________________
PHONE: _______________________ CELL: ____________________

PARTICIPANT____________________________________, HAS MY PERMISSION TO PARTICIPATE IN TRAINING, COMPETITION, EVENTS AND ACTIVITIES SPONSORED BY LBV. I APPROVE 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 BELOW. I ALSO CERTIFY TO THE BEST OF MY KNOWLEDGE THAT THE PARTICIPANT NAMED HEREON IS PHYSICALLY FIT TO ENGAGE IN THE ACTIVITIES DESCRIBED HEREIN.

SIGNED:_____________________________________ RELATIONSHIP:________________ DATE:_____________________
AS CUSTODIAL PARENT OR COURT-APPOINTED GUARDIAN OF______________________________________ (“CHILD”).
I DO FOR BOTH OF CHILD’S PARENTS, FOR CHILD AND CHILD’S HEIRS AND SUCCESSORS, RELEASE LADY BULLDOGS VOLLEYBALL, LLC. AND ANY OF ITS AGENTS OR REPRESENTATIVES (ALL OF THE FOREGOING COLLECTIVELY “LBV.”) FROM ALL CLAIMS ARISING OUT OF OR CONNECTION WITH CHILD’S PARTICIPATION IN ANY LBV PROGRAM OR TOURNAMENT, INCLUDING BUT NOT LIMITED TO INFECTIOUS DISEASES SUCH AS COVID-19. I PROVIDE THIS RELEASE BECAUSE I AM MINDFUL THAT ATHLETICS, PHYSICAL TRAINING AND COMPETITION CAN BE A DANGEROUS UNDERTAKING REGARDLESS OF HOW CAREFUL OR PRUDENT ANY PERSON, FIRM OR FACILITY MIGHT BE. FURTHER, I GIVE PERMISSION TO LBV TO TREAT CHILD OR ARRANGE FOR MEDICAL CARE OR TREATMENT FOR CHILD IN ANY SITUATION DEEMED REASONABLY NECESSARY BY LBV. IF CIRCUMSTANCES PERMIT, LBV SHALL ATTEMPT TO COMMUNICATE FIRST VIA TELEPHONE WITH THE FOLLOWING EMERGENCY CONTACTS FOR CHILD.

PRIMARY EMERGENCY CONTACT: SECONDARY EMERGENCY CONTACT:

____ ____
(NAME AND RELATIONSHIP) (TELEPHONE #) (NAME AND RELATIONSHIP) (TELEPHONE #)

IN THE EVENT NEITHER EMERGENCY CONTACT CAN BE REACHED OR IF THE URGENCY OF THE SITUATION REQUIRES IMMEDIATE ATTENTION WITHOUT PRIOR TELEPHONE CONTACT, LBV MAY ARRANGE FOR MEDICAL TREATMENT FOR THE CHILD AT THE EXPENSE OF THE PARENT OR GUARDIAN SIGNING THIS FORM. HEALTH INSURANCE INFORMATION FOR CHILD IS AS FOLLOWS:

INSURANCE COMPANY: ____ POLICY NUMBER: _____________
ADDRESS: ____________________________________ CITY: ________________ ST: ____ ZIP: _______________
TELEPHONE:(____)____

IN ORDER TO SEEK APPROPRIATE MEDICAL CARE OF TREATMENT OF CHILD, PLEASE DISCLOSE THE FOLLOWING:
ALLERGIES: _______________________________________ (PLEASE SPECIFY, ENTER “NONE”)
HEART DISEASE OR OTHER: ____________________________ (PLEASE SPECIFY, ENTER “NONE”)
ANY OTHER CONDITIONS, SYMPTOMS OR DISABILITY WHICH WOULD OR MIGHT AFFECT MEDICAL CARE OR TREATMENT OR PARTICIPATION IN THE LBV PROGRAM: ____

____ ____________________________
SIGNATURE (CUSTODIAL PARENT OR COURT APPT. GUARDIAN) (DATE)