

# 2010 MEDICAL AUTHORIZATION / HB 1824 COMPLIANCE FORM

## Player Information – (Please Print Legibly)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Team: WOLVERINES \_\_\_\_\_ MAVERICKS \_\_\_\_\_ / Division: PEEWEES \_\_\_\_\_ 89ERS \_\_\_\_\_ JUNIORS \_\_\_\_\_ SENIORS \_\_\_\_\_

### Parent/Guardian Emergency Contact Information

<u>Parent / Guardian 1</u> Full Name	<u>Parent / Guardian 2</u> Full Name
Relationship to Player	Relationship to Player
Home Phone	Home Phone
Cell or Work Phone	Cell or Work Phone
**Email Address	**Email Address

### Family Doctor Contact Information

Physician	Medical Conditions
Phone	Allergies
Treatment Facility	Medications

## Medical Authorization / Liability Waiver / HB 1824 Compliance Statement

**Medication Authorization – Grant of Consent.** I hereby certify that my child is in good health and may participate in all activities. In case of an emergency, I give my permission for my child to be given emergency treatment at any responsible accessible hospital.

**Liability Waiver:** As the parent (or legal guardian) of the above named minor, I grant permission for the minor to participate in all activities of the sports program. I assume all risk and hazards incidental to such participation, including transportation to and from such activities, and do hereby release and waive all claims against Mukilteo Wolverines & Meadowdale Mavericks Board Members, Staff, Coaches, volunteers, sponsors, volunteers, agents, other participants, Arlington, Bothell, Brier, Edmonds, Everett, Lake Stevens, Lakewood, Lynnwood, Marysville, Mill Creek, Monroe, Mountlake Terrace, Mukilteo, Snohomish, and Stanwood School Districts or any other School Districts we may participate in.

**HB 1824 Compliance Statement:** I have been provided with information on **concussions in youth sports**. If the player is suspected of a Head injury or Concussion, the player will be removed from play. The player will be kept from play until given permission to return to play by a health care provider.

[www.cdc.gov/ConcussionInYouthSports](http://www.cdc.gov/ConcussionInYouthSports)

Signature of Parent / Guardian: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date \_\_\_\_\_

Signature of Player : \_\_\_\_\_ Print Name: \_\_\_\_\_ Date \_\_\_\_\_

**Send Form to:**

**MYS**  
P.O. Box 203  
Mukilteo, WA 98275