



BARBARIANS RUGBY CLUB – MEDICAL FORM

Player name _____ DOB _____ Age _____

Address _____

City & Zip _____

Parent/Legal Guardian _____

Home Phone _____ Cell Phone _____

In order to compete in youth rugby your son/daughter must have passed a physical within the last year and your child **must** be covered by a health insurance plan. Rugby is a contact sport and injuries can happen and **risks of serious injury do exist** including permanent disability and death which may result from your own actions, inactions of others, the rules of play or the conditions of the premises or any equipment used. Further, there may be risks not known to us or not reasonably foreseen at this time. Your signature indicates that you are aware of the potential injury risks that could occur during a properly supervised practice or game and that you give your permission for your child to participate and that you have fulfilled its **medical insurance coverage requirement in Section 8 of the Waiver of Liability and Eligibility form.**

Parent/Legal Guardian signature _____ Date _____

MEDICAL EMERGENCY AND INSURNACE INFORMATION
(Please include a copy of your medial Insurance Card)

- | | | | |
|-----|--|-----|----|
| 1. | Are there any injuries requiring medical attention? | Yes | No |
| 2. | Are there any past surgeries or scheduled surgeries? | Yes | No |
| 3. | Is the participant currently under the care of a medical practitioner | Yes | No |
| 4. | Is the participant currently taking and medications? | Yes | No |
| 5. | Does the participant have any allergies (penicillin, Bee stings etc)? | Yes | No |
| 6. | Does the participant have asthma/require use of an inhaler? | Yes | No |
| 7. | Is the participant diabetic/require medication for diabetes? | Yes | No |
| 8. | Does/has the participant have/had seizures? | Yes | No |
| 9. | Does the participant wear glasses or contact lenses | Yes | No |
| 10. | Does the participant wear a brace or other medical support device? | Yes | No |
| 11. | Does the participant have any other physical conditions or medical conditions? | Yes | No |

If you answered yes to any of the above questions, please provide the question number and an explanation in the following space:

Family Doctors Practice _____

Doctors Name _____

Emergency Contact _____ Relationship _____

Emergence Contact Phone Number _____

Insurance Company Name _____

Insurance Policy Number _____ Membership Number _____

Name on Policy _____

I hereby certify that this information is complete and accurate to the best of my knowledge. I, the natural parent/Legal Guardian, authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment. Furthermore, I hereby acknowledge that it is my responsibility to inform my child's coach or organization official in writing if there is any change in the medical condition of my child. I also understand that it is my responsibility to obtain written permission from my child's physician on official medical stationary in order to seek permission for my child to resume participation after any and all such injury, illness or accident.

Parent/Legal Guardian signature _____ Date _____

Relationship to participant _____