



**Medical Form:**

<b>Player Name:</b>
<b>Address:</b>
<b>Phone Number:</b>
<b>Birth Date:</b>
<b>Email Address:</b>
<b>Health Care Number:</b>
<b>Doctor Name and Phone number:</b>
<b>Any medical concerns:</b>

**PARENTS:** The undersigned agrees that the *Medicine Hat Lacrosse Club*, it's officials and administrators will not be held responsible for any accident, injury or loss, and agree to release the *Medicine Hat Lacrosse Club*, it's officials and administrators from all claims or damages which may arise as a result of, or by reason or such accident, injury or loss.

<b>Signature of Parent:</b> _____
<b>Date:</b> _____