

Team Name _____ Jersey # _____

2008 Summer Shoot-out at RPI

Assumption of Risk / Release

Players will not be able to participate without a signed form.



Participant's Name: _____

(Please print clearly)

I, _____, am the parent/legal-guardian of, _____, ("Player") who has my permission to participate in the lacrosse tournament of the Albany Power Lacrosse Club ("Albany Power"), Albany, New York, during all, or part, of the 2008 calendar year. I know that lacrosse is a contact sport that is inherently dangerous and involves risks of injury or even death. Furthermore, I acknowledge that there are ever-present risks in life generally and that during my child's involvement in the Albany Power tournament, playing in a game, practicing, or otherwise engaged in the Albany Power program, there will be such risk. I knowingly and voluntarily assume these risks, and hereby release and hold harmless the Albany Power Lacrosse Club, its directors, RPI, and all of its agents, representatives, and assigns, from all liability, claims, rights or causes of action which may accrue as a result of personal injury or property loss or damage sustained by Player arising out of, or as a consequence of, Player's participation in the Albany Power tournament.

I hereby authorize Albany Power personnel and coaches to authorize the performance of emergency treatment for children who incur injury or become ill, whose parents or guardians cannot be reached through reasonable efforts under the circumstances. I can best be reached at this number: _____.

As a parent/guardian, I authorize the treatment of my child _____, by a qualified and licensed medical professional, in the event of injury or sickness for which medical and/or surgical treatment is deemed appropriate by a qualified and licensed medical professional. This release is effective during any period of time in which my child is participating in the Albany Power Lacrosse Program ("Albany Power") for the 2008 calendar year. I also hereby acknowledge my full and sole responsibility for payment of fees or costs for any treatment that my child receives pursuant to this Consent.

Signature of parent/guardian: _____ Date: _____

Parent home address _____

Printed name of parent/guardian: _____ Phone: _____

Alternate person to notify: _____ Relationship: _____

Phone: _____

Family Doctor: _____ Phone: _____

My child is a member of U.S. Lacrosse (Not Required): _____ Membership Number: _____

Facts concerning the child's medical history including allergies, medications being taken, medications causing an allergic reaction, and any physical impairment or condition about which a physician should be alerted: (Elaborate back of this form if necessary.)

*Please Print information as clearly as possible.