2016-2017 Oakland Warthogs Youth Rugby Program

MEDICAL FORM

Participant Name / Birth date:_____ **Weight**:_____

Assumption of Risk and Consent for Treatment

I understand that there is an inherent risk of injury with my participation and contact Rugby, and that this injury may lead to permanent disability or death. In the event of routine of emergency health examinations diagnostic procedures, treatment of illness, and/or injuries, permission is hereby granted to treat the athlete above by any medical staff, rugby staff, and physicians associated with other community facilities as needed.

Name of Parent / Guardian:_____ Date:_____

Signature of Parent / Guardian:_____ Date:_____

Signature of Student:_____ Date:_____

Emergency Contact #:_____ Date:_____

Medical Insurance Information

Indicate the status of your personal health insurance coverage. If covered, the information indicated below **must** be provided for **all** applicable policies.

_____I am **NOT** covered by a health/accident insurance policy.
_____I am covered by my own health/accident insurance policy.
_____I am covered by my parent's health/accident insurance policy.

Health Insurance Company Name and Address:_____

_____

Group #:_____ **Policy #:**_____

Physician Consent:

Height: _____ Weight:_____ Blood Pressure:_____

Allergies:_____

Medication student-athlete is taking:_____

Previous Medical Conditions:_____

Previous Orthopedic Conditions:_____

_____Student-athlete cleared for all full contact physical activities (full contact rugby football)

_____Student-athlete restricted from physical activities, reason and/or conditions for clearance (if any)

Conditions for Clearance (if any):_____

_____

Signature of Doctor:_____ Date:_____

*** (Doctor's stamp of approval also required)**