

# Gold Star Futsal Tournament

Participant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Team: \_\_\_\_\_

Coach: \_\_\_\_\_ Coach's Cell Phone#: \_\_\_\_\_

Parent/Guardian (Please print): \_\_\_\_\_

Parent/Guardian Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy No: \_\_\_\_\_

Participant's Physician: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Participant's Known Allergies/Medical Conditions: \_\_\_\_\_

## LIABILITY AND MEDICAL RELEASE

Signatures on this form signify each person has read, understands and abides by this information. There are risks connected with my participation in this tournament and its related activities. I release, waive, discharge and covenant not to sue WM Futsal, Gold Star Sports, City of Chicopee, City of Springfield, and affiliated groups or organizations, event sponsors, event charities and their workers, employees and directors, and the staff and organizers from all action, suits and demands whatsoever in law or in equity from demand, losses or damages on account of injury including death caused in whole or in part by the negligence of the release or otherwise. Further, I hereby grant full permission for event organizers to record any or all of my participation in this event for photos, motion pictures, TV, radio, recordings, videotapes, and other media known or unknown, and to use them, no matter by who taken, in any manner for publicity, promotions, advertising, commercial purposes.

In the event of an accident, injury, or sickness with respect to the undersigned participant, the undersigned parent gives his/her authority to the coach listed above to oversee the medical treatment until such time as the undersigned parent can be contacted. The undersigned parent also assumes responsibility for payment of any and all medical treatment provided to the undersigned participant. In the case of an emergency, the player may be provided emergency medical services prior to informing the parent or guardian. In case a parent/guardian cannot be reached, the coach listed above is designated to oversee the medical treatment until such time as a parent/guardian can be contacted.

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Player's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signed forms must be presented at time of team registration and check in.