



# Forsyth Water Polo Medical Release

Player's Name: \_\_\_\_\_

Name on Insurance Card: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group Number: \_\_\_\_\_

Primary Care Physician:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please list any medical conditions that may affect the participant's safety, health, stamina, or performance while participating in the sport of water polo: \_\_\_\_\_

List any medications your child is taking: \_\_\_\_\_

Is your child allergic to any medications? (Circle) Yes / No

If yes, please specify: \_\_\_\_\_

It is unsafe and prohibited to play or practice water polo while wearing prescription eyewear, due to the potential for eye injury. Soft lens, pool safe contact lenses are permitted. Mouthpieces are strongly recommended for players with orthodontics in place.

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**Medical Waiver:** I, the undersigned hereby certify that I am the parent or legal guardian of the above named participant/athlete. I hereby give my permission for any directors associated with the **Forsyth Water Polo Team**, or the in-use Aquatic Center to seek and/or give appropriate medical attention for my child in the event of an injury or illness. I, the undersigned will be responsible for any and all costs associated with any necessary medical attention and/or treatment.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Contact #1:

Emergency Contact #2:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_