

## **Waiver of Liability, Release, Assumption of Risk & Indemnifying Agreement**

I hereby grant permission for my child \_\_\_\_\_ to participate on the Southside Rugby Club. In consideration of the acceptance of my child to participate in an athletic recreational program as outlined herein, I hereby waive all claims against the city of Minneapolis, The Southside Rugby Club, the Minneapolis & Richfield School Districts, Minnesota Youth Rugby, the Minnesota Rugby Football Union, the Minnesota Amateur Rugby Foundation, their employees, trustees, agents, coaches, sponsors, organizers, members, directors, officers, supervisors, administrators, representatives, and participants from all claims for injuries suffered by me or by my child incidental to, connected with or arising out of negligence of the above named parties; but not including injuries suffered as a result of willful, intentional misconduct or gross negligence.

I do hereby waive, release, absolve, indemnify, and agree to hold harmless the above named parties from and against any claim out of injury to my child incidental to, connected with, or arising out of the Southside Rugby Club activities.

I understand and acknowledge that the City of Minneapolis, the Southside Rugby Club, the Minneapolis and Richfield School Districts, Minnesota Youth Rugby, the Minnesota Rugby Football Union, or the Minnesota Amateur Rugby Foundation; DO NOT HAVE HEALTH INSURANCE COVERING MY CHILD, which is my responsibility to provide.

I certify that to the best of my knowledge, my child has no physical infirmities or sickness that would limit or prevent his full participation except as follow: \_\_\_\_\_

Parent/Legal Guardian Signature Approval: \_\_\_\_\_ Date: \_\_\_\_\_

### **Medical Consent**

The coaches and chaperones of the Southside Rugby Club have my permission to seek immediate and appropriate emergency medical or dental treatment for my child should the need arise.

Parent/Legal Guardian Signature Approval: \_\_\_\_\_ Date: \_\_\_\_\_

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone(s): \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Contact Addresses or Phone (If different): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact Address: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance Provider: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Known Allergic Reactions: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dental Insurance Provider: \_\_\_\_\_ Group Number: \_\_\_\_\_

Other Information: \_\_\_\_\_