WBS KNIGHTS
MEDICAL INFORMATION FORM

ATHLETE'S NAME:

DATE OF BIRTH:

ADDRESS:

SCHOOL:

PARENT/GUARDIAN NAME:

HOME PHONE/CELL PHONE:

WORK PHONE:

OTHER EMERGENCY CONTACT:

CONTACT'S PHONE NUMBER:

PHYSICIAN NAME:

PHYSICIAN'S PHONE NUMBER:

INSURANCE SUBSCRIBER:

INSURANCE COMPANY:

POLICY NUMBER:

GROUP NUMBER:

MEDICAL CONDITIONS:

FOOD/DRUG ALLERGIES:

My/Our child wishes to participate in youth ice hockey for the Wilkes-Barre/Scranton Knights during the 2023-2024 season.
I/We realize that there are numerous risks involved in participating in the above in the above listed sport. These risks could involve but are not limited to: sprains, contusions, broken bones, lacerations, concussions, permanent disability, internal injuries, paralysis and possible death. These risks could impair my/our child's future ability to earn a living, engage in business, social, recreational activities, and to generally enjoy life.
I/We have been informed about the various risks associated with our child's participation in the above listed sports and the potential injuries that may occur.
I/We will assume all responsibility and certify our/my child is in good physical condition and has undergone a sports physical in the past two (2) years. Further, I/we are unaware of any medical condition that would inhibit my/our child's participation except as noted on the Physician's Report. As a condition of our child's voluntary participation in the above-mentioned sports, I/we agree to accept all the previously mentioned risks as a condition of my/our child's participation.
I authorize the coaching staff to provide emergency medical treatment of any injury or illness of my child if qualified medical personnel consider treatment necessary. I further authorize any qualified licensed physician to render medical treatment which in his or her judgement may be deemed necessary in the care of my child. By entering my full name below, I attest that this constitutes my legal electronic signature on this form.
I acknowledge I have received and read a copy of this organization's HIPPA statement. My signature below indicates I agree with the terms, conditions, and authorizations noted in the HIPPA statement.

Parent/Legal Guardian

Date