

THIS FORM IS TO BE COMPLETED FOR ANY TRYOUT.

KUTZTOWN UNIVERSITY
HEALTH HISTORY/MEDICAL TREATMENT PERMISSION FORM

Name of Participant _____ Birth _____ Date _____ Sex _____ Age _____

Parent or Guardian _____

Home address _____ Phone _____

Business address _____ Phone _____

Other Emergency Contact _____

Home address _____ Phone _____

Business address _____ Phone _____

Team Trying Out For: _____ Date of Tryout _____

Health History: (give dates)

Heart Defect/Disease _____
Convulsions _____
Diabetes _____
Hypertension _____
Mononucleosis _____
Bleeding/Clotting Disorder _____
Frequent Ear Infections _____

Diseases: (give dates)

Chicken Pox _____
Measles _____
German Measles _____
Mumps _____

Allergies: (give dates)

Hay Fever _____
Ivy Poisoning _____
Insect Stings _____
Penicillin _____
Other drugs _____
Asthma _____

Operations or serious injury (dates): _____

Disability or chronic recurring illness: _____

Dietary modifications: _____

Current medication taking: _____

Do you carry family medical/hospital insurance? _____ Carrier _____ # _____

I, the undersigned parent/guardian, do hereby grant permission for my son/daughter, named above, to attend the tryout named above. In order that my son/daughter may receive the proper medical treatment in the event that he/she may sustain injury or illness during the period of the above tryout, I hereby authorize the coaching staff to obtain or provide medical treatment for my son/daughter for such injury or illness during the tryout, and I hereby hold the University, as well as its representatives, harmless in the exercise of this authority.

I further understand that there is always a possibility that my son/daughter may sustain physical illness or injury while at a tryout at Kutztown University. If this occurs, I hereby authorize coaching staff and Kutztown University representatives to refer my son/daughter to a medical treatment center (hospital, etc.). I further acknowledge and understand that I will be responsible for any medical bills that may be incurred on behalf of my son/daughter for physical illness or injury that he/she may sustain during the tryout.

Understanding that there is always a possibility that my son/daughter may sustain physical illness or injury, I acknowledge and understand that my son/daughter is assuming the risk of such physical illness or injury by his/her participation, and I further release Kutztown University Foundation and its representatives and Kutztown University and its representatives from any claims for personal illness or injury that my son/daughter may sustain during the tryout. I further acknowledge and understand that my son/daughter will be responsible for his/her failure to abide by the rules and regulations of the tryout named above or of Kutztown University.

Signed _____ Date _____ Phone _____

THIS FORM IS TO BE RETURNED TO THE COACH RESPONSIBLE FOR YOUR TRYOUT

THIS FORM IS TO BE COMPLETED BY PARTICIPANTS
ATTENDING ANY KUTZTOWN UNIVERSITY
TEAM TRYOUT

**Informed Consent Release
And
Express Assumption of Risk**

I, _____, desire to participate in _____ tryouts
(Name) (Team Holding Tryout)

At Kutztown University on _____.
(Date of Event)

I realize injuries can be a consequence of participation in this activity and no amount of reasonable supervision or use of facility will prevent injury. I appreciate the character of the risk involved and I voluntarily assume (on behalf of my child if participant is a minor) all risk of possible death, harm or injury. I understand and appreciate that such injury could also include, without limitation, serious or permanent injuries to all bodily organs and functions. I am aware of the risk of participation in this designated activity. I have carefully considered how the possible consequences of injury may impact my life (or my child's life), and I choose to accept the risk involved (and allow him/her, if minor child) to participate in the designated activity.

In accepting this risk, I expressly and explicitly release, discharge and waive any and all responsibility of Kutztown University, Pennsylvania's State System of Higher Education, the Commonwealth of Pennsylvania, and the employees, officials or agents of any and all of the foregoing, pursuant to, or pertaining or related to, arising from, in any manner, injuries to myself (my child) as a result of my (his/her) participation in this activity.

By my signature below, I certify that I completely understand this document.

Signature of Participant Date

Signature of Parent or Guardian (if participant is a minor) Date

Witness Date