Legacy Youth Sports of Florida

Emergency Treatment/Contact Form & Waiver

Participants Name _____ Participant's Birthday ___/___/___

Doctors Name _____ Doctors Phone Number _____

Dentist Name _____ Dentist Phone Number _____

►Parents /Guardian - PLEASE LIST IN ORDER OF WHO WE SHOULD CONTACT FIRST◄

Parent/Guardian Name _____ Relationship to Participant _____

Home Phone _____ Cell Phone _____ Work Phone _____

Parent/Guardian Name _____ Relationship to Participant _____

Home Phone _____ Cell Phone _____ Work Phone _____

✪ Other Emergency Contacts– Emergency Contacts will ONLY be called if we cannot contact you ✪

Other Emergency Contacts (If Parents/Guardians Cannot be Reached):

Name _____ Relationship to Participant _____

Home Phone _____ Cell Phone _____ Work Phone _____

Name _____ Relationship to Participant _____

Home Phone _____ Cell Phone _____ Work Phone _____

I hereby give my consent for this child to participate in Legacy Youth Sports of Florida. My child will receive emergency care from the club. In the event of a serious accident or illness and I cannot be reached, I hereby authorize Legacy Youth Sports of Florida to contact the physician or dentist and for those professionals to provide protected health information as listed on the Legacy Youth Sports of Florida Preparticipation Physical Evaluation and those also listed on this form. In the event of an EMERGENCY, I understand that the club will access the 911 emergency medical system immediately. To expedite care, I give my permission for Legacy Youth Sports of Florida personnel to provide medical information to the responding emergency team to initiate treatment, and transport to an appropriate facility. I give my permission for the appropriate medical personnel and staff to initiate treatment immediately upon arrival to the appropriate facility. I request to be notified of my child's condition and admission as soon as possible. If I cannot be reached, I request that the admitting facility notify one of the other persons listed above of my child's condition and admission. I agree to be financially responsible for my child's total treatment, and transport. I have reviewed the above information and have made corrections as needed.

- I/We understand that by signing this form, we have 30 days to have a physical completed for the participant and if we fail to provide a physical with-in 30 days we understand that the participant will not be able to participate until the physical is completed.
- I/We understand that this form is good for One Calendar Year from Date Signed and we agree to update the form with LYS when changes need to be made.
- I/We understand that this consent includes first aid, transportation to/from health care providers, and treatment.

Parent's Printed Name _____ Parents Signature _____ Date _____

Parent's Printed Name _____ Parents Signature _____ Date _____