Lightning Flag Football
Medical Release Form 2023-2024

Player: _____ D.O.B.:_____

Address: _____

City:_____ State:_____ Zip:_____

Parent/Legal Guardian: _____

Phone: H: _____ W: _____ Cell: _____

Parent Email 1:_____ Parent Email 2: _____

Player Email: _____

Other Emergency Contact: Name: _____

Relationship to Player: _____ Phone: _____

I hereby give my permission for _____ to participate in the LIGHTNING Football program. I understand that, in the event that medical treatment is required, every effort will be made to contact me. If I cannot be reached, I give my permission to the sponsor to give first aid to my child and/or to secure the service of a licensed medical care provider to provide the care necessary, including anesthesia, for my child's well-being. I also understand that all medical expenses will be my responsibility, and that no member of the Lightning Football organization will be held responsible for medical expenses.

Primary Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Insurance Co: _____ Policy #: _____

Date of last tetanus shot: _____

Please list any medical allergies, medications being taken, medical problems, or other pertinent information:_____

_____

_____

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____ Date:_____