

**2019 High School Summer League**

**Circle one: Monday    Tuesday    Wednesday    Thursday**

**Athletes Name:** \_\_\_\_\_

**School:** \_\_\_\_\_

**Release Permission to Treat & Emergency Information**

As custodial parent or court-appointed guardian of \_\_\_\_\_ ("Child"), I do for both of Child's parents, for Child and Child's heirs and successors, release GLV, INC. and any of its agents, employees, or representatives (all of the foregoing collectively "GLV INC.") from all claims arising out of or connected with Child's participation in any GLV, Inc. Program. I provide this release because I am mindful that Athletics, Physical Training, and competition can be a dangerous under-taking regardless of how careful or prudent any person, firm or facility might be. Further, I give permission to GLV Inc. to treat Child or arrange for medical care or treatment for Child in any situation deemed reasonably necessary by GLV, Inc. If circumstances permit, GLV, Inc. shall attempt to communicate first via telephone with the following emergency contacts for Child:

**Primary Emergency Contact: Secondary Emergency Contact:**

\_\_\_\_\_

**Name and relationship/telephone number Name and relationship/telephone number:**

\_\_\_\_\_

In the event neither emergency contact can be reached or if the urgency of the situation requires immediate attention without prior telephone contact, GLV, Inc. may arrange for medical treatment for the child at the expense of the parent or guardian signing this form. Health Insurance, PPO information for Child is as follows:

**Insurance Company:** \_\_\_\_\_ **Policy Number** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

In order to seek appropriate medical care of treatment of Child, please disclose the following:

**Allergies:** \_\_\_\_\_ (Please specify, enter "None" or leave blank)

**Heart Disease or other:** \_\_\_\_\_ (Please specify, enter "None" or leave blank)

**Any other conditions, symptom or disability which would or might affect medical care or treatment of participation in the GLV, Inc. program:** \_\_\_\_\_

\_\_\_\_\_ (Please specify, enter "None" or leave blank)

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Custodial parent or guardian

**Please give to your high school coach before the 1<sup>st</sup> league date or bring it to your first league date and give it to them. Do not send this to the Great Lakes Center, thank you.**