MEDICAL RELEASE, CONCUSSION ACKNOWLEDGMENT, HIPAA AUTHORIZATION & EMERGENCY CONSENT

ASSUMPTION OF RISK & MEDICAL RELEASE

I, the undersigned parent/legal guardian ("Guardian"), acknowledge that participation in youth football and cheerleading involves inherent risks, including but not limited to bodily injury, concussion, traumatic brain injury, fractures, heat-related illness, permanent disability, paralysis, or death. I knowingly and voluntarily assume all risks associated with participation, whether known or unknown.

I certify that the minor participant is physically fit to participate and that I will disclose any relevant medical conditions. In the event that I cannot be reached, I authorize Patriots of Wellen Park Football & Cheer Organization, its directors, officers, coaches, volunteers, agents, and representatives to obtain emergency medical treatment, hospitalization, surgical procedures, anesthesia, or other medical services deemed necessary by licensed medical professionals.

I agree to assume full financial responsibility for any and all medical expenses incurred and release and hold harmless the Organization and its representatives from liability arising from emergency medical care rendered in good faith.

CONCUSSION & HEAD INJURY ACKNOWLEDGMENT

I understand that a concussion is a serious brain injury that may occur from direct or indirect contact to the head or body. I acknowledge that symptoms may not appear immediately and that returning to play prior to full recovery increases the risk of second-impact syndrome, permanent neurological damage, or death.

In accordance with Florida Statute §1006.20(2)(j), the participant will be immediately removed from play if a concussion or head injury is suspected and may not return until medically evaluated and cleared in writing by an appropriate licensed healthcare provider.

PARTICIPANT INFORMATION

Athlete Name: _____

Date of Birth: _____ Age: _____ Sport: _____

Parent/Guardian Name: _____

Primary Phone: _____ Email: _____

Emergency Contact Name: _____ Phone: _____

INSURANCE INFORMATION

Insurance Company: _____

Policy Number: _____ Group Number: _____

Preferred Hospital: _____

MEDICAL INFORMATION

Primary Care Physician: _____ Phone: _____

Allergies: _____

Medications: _____

Existing Medical Conditions: _____

HIPAA AUTHORIZATION

I authorize licensed healthcare providers to disclose protected health information (PHI) to Organization representatives as necessary for emergency treatment and insurance processing in accordance with HIPAA. This authorization remains effective during participation unless revoked in writing.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____