Liability Waiver and Medical Treatment Authorization Form

Hub City Fastpitch (Aberdeen, SD)

By completing this form, I am registering my child to play for the Hub City Fastpitch softball team. I understand there are risks inherent to the sport of softball and I accept the full responsibility for the health and participation of my child in this sport. I agree that my daughter's participation is fully voluntary, and I will not hold any persons associated with the Hub City Fastpitch, coaches or other parents, responsible for any harm that may results from participation.

I hereby give my consent to have an athletic trainer, coach, team manager, emergency medical technician, nurse, medical treatment facility, and/or doctor of medicine or dentistry or associated personnel provide the applicant/participant with medical assistance and/or treatment and agree to be financially responsible for the cost of such assistance and/or treatment. I understand treatment for injury will be based on information provided herein. I hereby authorize emergency transportation of the applicant/participant to a medical treatment facility should an individual listed above consider it to be warranted. I recognize the possibility of physical injury associated with softball, and hereby release, discharge, and otherwise indemnify the named club/group and its affiliated organizations, and the employees and associated personnel of these organizations, against any claim by or on behalf of the softball player named below as a result of that player's participation in South Dakota softball programs and/or being transported to or from the same, which transportation I hereby authorize.

By signing below, I understand there are risks associated with this sport and assume that risk and any associated costs for your daughter and family.

Child's Name: _____ Date of Birth: _____

Parents Name(s): _____

Address: _____

City: _____ State: _____Zip Code: _____

Phone #: _____ Email Address: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone #: _____

Medical Insurance: _____ Policy Holder Name:_____

Policy No./Group ID:_____ Preferred Health Facility: _____

Parent Name: _____

Parent/Guardian Signature: _____