2019 Santa Clarita Valley Youth Lacrosse Association Player Contract

SCV Blackhawks

TEAM

Name	
Street Address	
City,State, Zip	
Emergency Contact	
Emergency Phone	
Players DOB	

Insert Photo

Risk Warning – Informed Consent.

The SCVYLA is concerned about the health and welfare of all participants. Although there are low rates of incidents and accidents for youth participating in athletic activities, we feel that you should be aware that the safety equipment and protective gear, "Cannot guarantee it will prevent all injuries". For the protection of your child pre-participation examinations are recommended before any participating begins. Joining an athletic team is a privilege, not a right. I have been advised of the risk of sports, I realize that my child may be at an extra risk

Medical Conditions

I Have Read and Understand the Above: Parent/Guardian Signature Date

Parental Consent & Medical Treatment Authorization.

I/We the parents/guardians of the above named participant, hereby give my/our approval for participation in any and all SCVYLA activities during the current season. I/We assume all risks and hazards incidental to such participation including transportation to and from such activities; and I/We do hereby waive, release, absolve, indemnify, and agree to hold harmless the local team, chapter, league, and other organizations this football program is affiliated with, the organizers, sponsors, supervisors, coaches, and other participants, and persons transporting my/our child to and from such activities or games for any claim out of injury to my/our child. The League has "Secondary Excess Accident Medical Group Insurance Coverage" only, over any valid collectable coverage provided by the parents' separate personal or employee's dependent group insurance.

In executing the forgoing release, I/We the undersigned acknowledge and represent that (A) I/We understand that any claim for injury must be reported to the players coach and/or an authorized organization/SCVYLA official within 30 days of the injury. (B) I/We understand that any monies I/We paid to the team/Chapter our child is affiliated with, does not constitute a premium payment for insurance coverage.

Name of Personal or Group Insurance Carrier	Group #	Plan #

I/We hereby grant authority to a qualified Doctor of Medical or Physician such medical treatment, as said Doctor or Pysician deems necessary under the circumstances.

Parent/Guardian Signature Printed Name Relationship Date