Downingtown Rugby Football Club
***********Player Information*********

First: _______________Middle: _______ Last:________________ Nick Name: _________ M/F

Address: ____

Birth Date: ____________ Dues: $ ______ Dues paid: __________ (date)

Cell: _____________ Work Phone: ______________Email:___________________________

School: ___________________ Grade: ______

Height: __________ Weight: ________ Short/waist Size: ___________ Shirt size ______

Previous Medical History: ____

Medications: ________________________ Allergies: _______________________________

Family Physician: ___________________________ Physician Phone: ___________________

Family Dentist: _____________________________ Dentist Phone: ____________________

Insurance Company: _______________________________________

Ins Policy # : _________________________ Ins Policy Holder: ________________________

Emergency Contact: ____________________________ Relationship: ___________________

Emergency Contact Phone: ____

Authorization to Consent to Immediate Medical Treatment of Minor

In connection with my (our) son/daughter's participation in the Downingtown Rugby Football Club, I (we), the parent/legal guardian (s), authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I (we) cannot be contacted. I (we) waive, my (our) right of informed consent to such treatment. I(we) waive all claims against the above referred to adults, physicians, hospitals, and their employees, ambulatory care, etc., in connection with the decisions for immediate care.

Name of Parent./Legal Guardian (Please Print)	
(X) Signature of Parent/Legal Guardian	**Date**
Name of Player (please Print)	
(X) Signature of Player	**Date**