WAIVER FORM

PERSONAL INFORMATION

Participant Name _____

Address _____

Street City Postal Code

Home # _____ Business # _____ ext.____ Cell # _____

E-mail _____ Date of Birth _____

day | month | year

MEDICAL HISTORY

Name of person to contact in an emergency _____

Person's Phone # _____ Person's Cell # _____

Asthma ◯NO ◯YES If YES, please describe : _____

_____

Tendonitis or other chronic conditions ◯NO ◯YES If YES, please describe condition & treatments :

_____

_____

PLEASE NOTE : ALL Information is confidential.

We : _____ & _____ give permission for

our son / daughter _____ to participate with the I Love Water Polo Program.

Signed : Mother / Guardian _____ Date_____

And / or : Father / Guardian _____ Date_____

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