Springfield College Athletic Department
Boy's Lacrosse Preseason High School Tournament
March 10, 2024
Waiver of Liability

(Phone: 413-426-5883; email: kbugbee@springfieldcollege.edu)

Participant Name (print): _____

Authorization to Participate/Assumption of Risk: I understand and certify that my child's participation at Springfield College and its activities is completely voluntary and I have familiarized myself with the program and activities in which my child will be participating. I recognize that certain hazards and dangers are inherent within the clinic. I understand that Springfield College does not provide medical insurance coverage and therefore take full responsibility for any medical costs incurred due to my child's participation. I certify that my child is in good health and able to participate fully in the activities of the Clinic. I acknowledge that although Springfield College has taken safety measures to minimize the risk of injury to participants, Springfield College cannot insure nor guarantee that the participants, equipment, premises, and/or activities will be free of hazards, accidents, and/or injuries. I understand that in consideration of the opportunity to participate in the Clinic, I on behalf of my child and his/her parents/guardians hereby release Springfield College, its trustee, officers, employees, agents, volunteers and representatives from all liability claims, suits or actions for any loss, damage, injury to person or property or death resulting from or arising out of my child's participation in the Clinic. **If clinic rules are not followed, my child may be sent home.**

Signature of parent/guardian: _____ **Date**: _____

Name of parent/guardian (print): _____

Emergency Authorization: I hereby give permission to the physician selected by a representative of Springfield College to order x-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by a representative of Springfield College to hospitalize, charge my health insurance, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my child as named above.

Signature of parent/guardian: _____ **Date**: _____

Name of parent/guardian (print): _____

Emergency phone contact number for day of clinic: _____

Physician _____ **Phone**: _____

Insurance Company: _____ **Policy number**: _____

I hereby grant to Springfield College all rights necessary to enable Springfield College to use, reproduce, assign, and/or distribute, in all forms and in any media, my image and/or photograph or video, and any such other items related to my participation in the clinic for promotion and/or education purposes.

Signature of parent/guardian: _____ **Date**: _____