

**THIS FORM IS TO BE COMPLETED FOR ANY EVENT  
PARTICIPANT UNDER THE AGE OF 18.**

**Fellowship of Christian Athletes (FCA)  
Health History/Medical Treatment Permission Form**

Name of Attendee \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Parent or Guardian \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Phone \_\_\_\_\_

Other Emergency Contact \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of Event Attending: 2007 High School OW2P Tournament July 13-14, 2007

**Health History: (give dates)**

Heart Defect/Disease \_\_\_\_\_  
 Convulsions \_\_\_\_\_  
 Diabetes \_\_\_\_\_  
 Hypertension \_\_\_\_\_  
 Mononucleosis \_\_\_\_\_  
 Bleeding/Clotting Disorder \_\_\_\_\_  
 Frequent Ear Infections \_\_\_\_\_

**Diseases: (give dates)**

Chicken Pox \_\_\_\_\_  
 Measles \_\_\_\_\_  
 German Measles \_\_\_\_\_  
 Mumps \_\_\_\_\_

**Allergies: (give dates)**

Hay Fever \_\_\_\_\_  
 Ivy Poisoning \_\_\_\_\_  
 Insect Stings \_\_\_\_\_  
 Penicillin \_\_\_\_\_  
 Other Drugs \_\_\_\_\_  
 Asthma \_\_\_\_\_

Operations or serious injury (dates): \_\_\_\_\_

Disability or chronic/recurring illness: \_\_\_\_\_

Dietary modifications: \_\_\_\_\_

Current medication taking: \_\_\_\_\_

Do you carry family medical/hospital insurance? \_\_\_\_\_ Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

I, the undersigned parent/guardian, do hereby grant permission for my son/daughter, named above, to attend the event named above. In order that my son/daughter may receive the proper medical treatment in the event that he/she may sustain injury or illness during the period of the above event. I hereby authorize the FCA Lacrosse staff to obtain or provide medical treatment for my son/daughter for such injury or illness during the event, and FCA representatives, harmless in the exercise of this authority.

I further understand that there is always a possibility that my son/daughter may sustain physical illness or injury while at an event with FCA. If this occurs, I hereby authorize FCA Lacrosse representatives and to refer my son/daughter to a medical treatment center (hospital, etc.) I further acknowledge and understand that I will be responsible for any medical bills that may be incurred on behalf of my son/daughter for physical illness or injury that he/she may sustain during the event.

Understanding that there is always a possibility that my son/daughter may sustain physical illness or injury, I acknowledge and understand that my son/daughter is assuming the risk of such physical illness or injury by his/her participation, and I further release FCA, its representatives, and FCA Lacrosse representatives from any claims for personal illness or injury that my son/daughter may sustain during the event.

Signed \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

**“PLEASE COMPLETE THIS FORM AND MAIL IT BACK TO THE FCA  
LACROSSE OFFICE IN THE PROVIDED ENVELOPE”**