

**Haverford College Boy's Lacrosse Clinic Waiver Form**

I, \_\_\_\_\_, understand that my participation in the Dukes lacrosse clinic at Haverford College on October 10<sup>th</sup>, 2010 on Swan Turf Field and Featherbed Fields (the 'Event') exposes me to the possibility of serious injury as well as damage to clothes and personal property. I knowingly assume the risk of such property damage and injury, including the possibility of death, in connection with my participation in the Event regardless of how such property damage, injury, or death might arise, and regardless of who is at fault.

I, for myself and my heirs, administrators, successors and assigns, release and discharge Haverford College and its respective employees, representatives and agents, from any liability or claims that might arise from my participation in the Event.

I understand that it is my responsibility to obtain any insurance needed to cover personal injury or death and any liability I might incur to other participants in the Event.

I HAVE READ THIS WAIVER AND RELEASE OF LIABILITY, I FULLY UNDERSTAND ITS TERMS, AND I RECOGNIZE THAT I HAVE GIVEN UP RIGHTS BY SIGNING IT, IN CONSIDERATION OF MY BEING PERMITTED TO PARTICIPATE IN THE EVENT. I SIGN IT FREELY, VOLUNTARILY AND WITHOUT ANY INDUCEMENT.

I, \_\_\_\_\_, have read the above and fully understand it and with my signature, I consent to the above.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**MEDICAL RELEASE | HISTORY FORM**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

“I hereby certify that I am in good to participate in the lacrosse clinic at Haverford College. I authorize all medical and hospital procedures as may be performed in the case of an emergency. Haverford College, administrators and representatives are not responsible for any accident, medical/dental expenses or any other expense incurred as a result of my participation in the pickup basketball games.”

Signature: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Agreement/Group Nos: \_\_\_\_\_

I.D. No.: \_\_\_\_\_

Allergies: \_\_\_\_\_

Ailments: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Additional Information: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_