Club Sports Medical Information and Release Form

Club Name _____

Participant's Name: _____ Date of Birth: _____

Box#: _____ Telephone number: (___)_____
Student ID #_____
Permanent Address: _____

I. Emergency Contact Information
Contact Name: _____ Relationship to participant: _____
Telephone-Daytime: (____)_____ Nighttime: (____)_____

II. Medical/Hospitalization Insurance Coverage Information
Relevant emergency medical information (asthma, allergies to medication, previous history of seizures, heart or kidney disease, etc.):
_____
_____
_____
_____

Please check all that apply:
□ I am subscribed to the HWS Student Health Insurance Policy.
□ I have coverage through my parents' health insurance or a personal health insurance policy.

If so, please answer the following:
Name of Agency providing coverage: _____
Policy number: _____
Dates for which coverage is provided: From _____ to _____
Are you sure it covers you out of your home state and/or out of New York? Yes No

By signing below, I verify that: a) I have no physical impairments that might put myself or others in danger by my participation in club sports activities; b) I will abide by all HWS and applicable club sports regulations regarding my participation; and c) if I become injured in the course of my participation, and am unable to seek treatment for myself, I hereby give permission for emergency medical treatment to be sought for me by representatives of Hobart and William Smith Colleges.

_____ _____
(Signature of Participant) Date Signed

_____ _____
(Signature of Parent/Guardian if Participant is a minor) Date Signed