Arizona Power League
Medical Release and Waiver Form
2020-2021

Permission to Treat & Emergency Information Form must either be carried to Arizona Power League Event, Competition and Practices. The form MUST be completed legibly and signed in all areas by both the player and his/her parent or guardian.

BY SIGNING THIS FORM, THE PARTICIPANT AND GUARDIAN AFFIRMS HAVING READ IT.

Organization/Club/Team _____

Participant Name: _____

E-mail:_____Phone: _____

Address: _____

City:_____St._____Zip: _____

Participant as named above has my permission to participate in training, competition, events, activities, and travel sponsored by APL member club. I approve the leaders who will oversee this program. I recognize that the leaders are serving to the best of their ability. I certify that the participant has full medical insurance with the company listed below. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described herein.

Signed:_____
Relationship:_____Date: _____

AS CUSTODIAL PARENT OR COURT-APPOINTED GUARDIAN OF THE PARTICIPANT NAMED ABOVE, I DO FOR BOTH OF CHILD'S PARENTS, FOR CHILD AND CHILD'S HEIRS AND SUCCESSORS, RELEASE JVA, CORP. AND ANY OF ITS AGENTS OR REPRESENTATIVES (ALL OF THE FOREGOING COLLECTIVELY "APL.") FROM ALL CLAIMS ARISING OUT OF OR CONNECTION WITH CHILD'S PARTICIPATION IN ANY JVA INSURED CLUB, PROGRAM OR TOURNAMENT. I PROVIDE THIS RELEASE BECAUSE I AM MINDFUL THAT ATHLETICS, PHYSICAL TRAINING AND COMPETITION CAN BE A DANGEROUS UNDERTAKING REGARDLESS OF HOW CAREFUL OR PRUDENT ANY PERSON, FIRM OR FACILITY MIGHT BE.

Further, I give permission to APL insured member club to treat participant or arrange for medical care or treatment for child in any situation deemed reasonably necessary by APL insured member club. If circumstances permit, APL member club shall attempt to communicate first via telephone with the following emergency contacts for child.

Primary Emergency Contact:
Name/Relationship_____Phone _____

Secondary Emergency Contact:
Name/Relationship_____Phone_____

In the event neither emergency contact can be reached; or if the urgency of the situation requires immediate attention without prior telephone contact, APL insured member club may arrange for medical treatment for the participant at the expense of the parent or guardian signing this form. Health Insurance, PPO information for child is as follows:

Insurance Company: _____

Policy Number: _____

Address:_____Phone: _____

City:_____St:_____Zip: _____

To seek appropriate medical care or treatment of Child, please disclose the following:
Allergies:_____(please specify, enter "none")
Heart disease or other:_____(please specify, enter "none")
Any other conditions, symptoms or disability, which would or might affect medical care or treatment or participation in the APL program:

Signature of Custodial parent or court apt. Guardian _____

Date _____

Best Email Contact _____

IF REQUIRED BY THE PARTICIPATION STATE ( ):

STATE OF_____COUNTY OF_____SWORN TO BEFORE ME, a Notary Public, by said_____personally known to me this_____day of_____, 20_____.
_____(Notary Public)
My Commission Expires _____