



**DOS CRESCENT FOUNDATION INC.
INVICTA ATHLETIC PROGRAM
REGISTRATION FORM**



SPORTS			
CROSS COUNTRY		FLAG FOOTBALL	
BASKETBALL		TRACK	
VOLLEYBALL		WRESTLING	



Participants Name: _____ M.I.: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

School: _____ DOB: _____ M F

Mother's Name: _____ M.I.: _____ Last Name: _____

Phone Number: _____ Email Address: _____

Father's Name: _____ M.I.: _____ Last Name: _____

Phone Number: _____ Email Address: _____

LIABILITY WAIVER

I/(We), give permission for our child as named above, to participate in the Invicta Athletic Program/ DOS Crescent Foundation Inc. In addition, I/(We), the parent(s) of the above-named youth do hereby authorize any treatment or emergency care needed for said child by any licensed nurse, physician, or hospital while participating in the activities of the Invicta Athletic Program / DOS Crescent Foundation Inc.

As the parent(s)/next of kin and guardian of said minor, I/(We), forever release, acquit and discharge Invicta Athletic Program / DOS Crescent Foundation Inc. from any and all liabilities, claims and I/(We) or my/(our) representatives may have by reason of said emergency care. My/(Our) child is covered by If under 18 this permission slip **MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN.**

Signature of PARENT/Guardian: _____ Date: _____



ATHLETICS

Please Print Information

INVICTA ATHLETICIS PROGRAM
EMERGENCY MEDICAL RELEASE



Child's Full Name: Birthdate:

Allergies: Medicines Routinely Taken:

Name of Custodial Parent(s)/Legal Guardian(s):

Address: Street Address City State Zip Code

Home Telephone: Cell Telephone: Work Telephone:

Family Physician's Name/Health Care Resources:

Address: Street Address City State Zip Code

Telephone:

Hotel Preference: Name City

Medical Insurance Company:

Policy #: Expiration Date:

Emergency Contact (if custodial parent/guardian cannot be reached):

Address: Street Address City State Zip Code

Home Telephone: Cell Telephone: Work Telephone:

Sign in presence of the Notary.

I hereby give the consent to any emergency facility and physician to administer necessary treatment to my child
in the event of an emergency at which time I cannot be reached.

(Child's Full Name)

I give consent to transport by ambulance if situation warrants it.

Signature of Custodial Parent/Legal Guardian (Affiant)

STATE OF FLORIDA COUNTY OF

The foregoing instrument was acknowledged before me this (Month) (Day) 20 (Year)

by means of physical presence or online notarization by (Name of Affiant) who is personally known

To me or has produced as identification (Type of identification)

Signed: (Signature of Notary)