DOS CRESCENT FOUNDATION INC.
INVICTA ATHLETIC PROGRAM
REGISTRATION FORM

SPORTS			
CROSS COUNTRY	☐	**FLAG FOOTBALL**	☐
BASKETBALL	☐	**TRACK**	☐
VOLLEYBALL	☐	**WRESTLING**	☐

Participants 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: _____

INVICTA ATHLETICS PROGRAM
EMERGENCY MEDICAL RELEASE

Please Print Information

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: _____

Hospital 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 _____ _____ 20_____
(Month) (Day) (Year)

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

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

Signed: _____(Signature of Notary)