

# Kilgore College Rangerette Pre-Training and Tryouts Authorization for Medical Treatment & Emergency Contact

PARTICIPANTS NAME: \_\_\_\_\_

PARTICIPANTS DATE OF BIRTH: \_\_\_\_\_

Insurance Company (Medical): \_\_\_\_\_

Policy No. \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

**YOU MUST ATTACH A CURRENT COPY OF THE PARTICIPANT'S MEDICAL INSURANCE CARD**

Participants Physician: \_\_\_\_\_ Physician's Phone No.: \_\_\_\_\_

EMERGENCY CONTACTS (No one under the age of 18 is permitted to be listed):

Parent or Legal Guardian's Name: \_\_\_\_\_

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

Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Additional Contact Name: \_\_\_\_\_

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

Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_

CURRENT MEDICATIONS, LIMITATIONS, SPECIAL NEEDS, MEDICAL CONDITIONS OR ALLERGIES OF PARTICIPANT:

\_\_\_\_\_  
\_\_\_\_\_

Any other information that might help us to provide this participant with the best possible experience during our tryout:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION:**

**IF PARTICIPANT IS UNDER 18 YEARS OLD:** In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize Kilgore College or the Kilgore College Rangerettes (collectively "KC") to take my child to a nearby medical facility for necessary treatment or to administer necessary drugs or treatment. I further consent and authorize any and all necessary treatment for my child and I accept all financial responsibility for such treatment and understand that KC will not be responsible for any such medical costs.

In case of sickness or accident, I hereby authorize and consent to have medical personnel selected by KC to order and/or perform any medical attention or procedure deemed necessary. I understand and agree that KC and its employees will not, under any circumstances, be held responsible or liable in the event of accident or death arising out of or related to same medical attention and by signing below, I hereby release and agree to hold KC harmless for any claims or damages whatsoever related to any medical treatment or care provided to my child/me.

\_\_\_\_\_  
Parent or Legal Guardian's Signature (if Camper is under age 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Participant's Signature (if 18 or older)

\_\_\_\_\_  
Date