

**Diablo Valley Track & Field Club  
2011 Cross Country Release Form**

**ATHLETE (1) NAME:** \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex: M F

**2011 USATF#:** \_\_\_\_\_ **-OR-** **2011 USATF application form attached**

**ATHLETE (2) NAME:** \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex: M F

**2011 USATF#:** \_\_\_\_\_ **-OR-** **2011 USATF application form attached**

**Home address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Email\*:** \_\_\_\_\_

**(\*please write legibly – email is our primary means of communication!)**

**Mother's name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Father's name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Emergency contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Doctor:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Release of Liability and Medical Representations**

**Consent for Medical Treatment:** As the parent or legal guardian of the above named DVTF member(s) I hereby give my consent for emergency health care administered or prescribed by a duly licensed health care practitioner, EMT or paramedic.

**Medical Insurance:** My child(ren) participating in this program are included in a medical insurance policy that I maintain.

**Medical Condition:** My child(ren) have no medical conditions that require special attention, unless otherwise noted below.

**Liability Release:** for myself, children, heirs, executors, administrators and assignees, I hereby release all rights and claims for damage against DVTF, its coaches, club organizers, and other volunteers for any and all injuries suffered by my child(ren) or me traveling to and from and during practices and meets during the upcoming season. I also attest to the fact that my child(ren) is/are in good health, physically fit and able to participate in a track and field program.

**Fee(s):** I have enclosed a check for the required fees for the DVTF 2011 Cross Country program. If you decide by September 18 that the DVTF 2011 Cross Country program is not appropriate for your athlete, the required fee paid less \$25 will be refunded. After that date, all fees are non-refundable.

**I have read, understood and agree to the terms on this form.**

Signature of parent or guardian: \_\_\_\_\_ Date \_\_\_\_\_

Printed name:

**\*\*\* Medical condition(s) requiring special attention:** \_\_\_\_\_ **\*\*\***