

ALL PLAYERS must show up one hour early on the night of their first game to receive team assignments, jerseys and schedules. Please be prepared to play on this night.

In connection with the Applicant's participation in Hero's Lacrosse, Inc., Summer League, the undersigned do certify that the Applicant/player is in good health, has no physical impairment restricting him or her from playing lacrosse, except as herewith provided in writing to **H.L., Inc.**, and otherwise is able to participate in the program activities. We (are, are not) attaching a statement explaining special physical limitations and/or required medication, if any, (please indicate if the Applicant/player suffers from allergies, asthma, diabetes, restricted activities, etc.). In further consideration of **H.L., Inc.'s**, acceptance of this application, the undersigned, both for himself or herself and on behalf of any minor child for whom he or she is submitting this application, hereby agree(s) to indemnify and hold harmless, **H.L., Inc.**, its officers, directors, coaches, staff, workers, volunteers, agents, and sponsors from and against any and all liability, claims, actions, lawsuits, losses, judgments, and demands whatsoever, in law or in equity, arising out of or in any way relating to the Applicant's participation in any League event, including, but not limited to, personal injuries or injury to property sustained or caused by the Applicant during or as a result of participation by the Applicant in **H.L., Inc.** The Applicant is aware of the fact that lacrosse is a physically demanding and challenging sport in which injuries may occur.

Applicant Signature

Date

Parent Signature

Date

INSURANCE

Coverage for accidental injury is required by all participants. Please indicate your Family Health Insurance Plan below.

I have the required Insurance.

Health Insurance Co.

Policy Number

MEDICAL TREATMENT AUTHORIZATION

The undersigned hereby authorizes Hero's Lacrosse, Inc. and its agents to request medical assistance and to authorize medical treatment for and on behalf of the Applicant as deemed reasonable and necessary by an appropriate medical professional to protect the well being of the Applicant.

Applicant Signature

Date

Parent Signature

Date

**HERO'S LACROSSE, INC
PO BOX 852
SEVERNA PARK, MD 21146**

Register online at www.heroslacrosse.com