This form is kept with CSC coaches when traveling to competitions

CALIFORNIA SPORTS CENTER

Athlete: _____ **Level:** _____

CSC Training Location: Morgan Hill Great Oaks Race St. Cambrianna Sunnyvale

Contact Information (print or type). Today's Date: _____

Gender: _____ Athlete's Birthdate: _____ Preferred Tee size _____ Leo _____

Address: _____ City: _____ Zip: _____

Parent/ Legal Guardian Name _____

Home Phone (____) _____ Cell phone (___) _____

2nd Parent / Legal Guardian Name _____

Home Phone (____) _____ Cell phone (___) _____

Primary Team Communication email: _____

Health/Accident Insurance Carrier _____

Policy # _____ Company Policy Yes No

Doctor's Name _____ Hospital _____

Please describe any medical or health related concerns we should know about:

_____

Is the athlete allergic to any medications? Please describe: _____

_____

Emergency Release

IN THE EVENT OF AN EMERGENCY OR INJURY AND IN MY ABSENCE, I (Parent name) _____.

GIVE PERMISSION FOR A REPRESENTATIVE OF THE CALIFORNIA SPORTS CENTER TO AUTHORIZE MEDICAL TREATMENT FOR THE ABOVE NAMED ATHLETE.

THIS PERMISSION IS GRANTED FROM 8/01/2023 to 07/31/2024 (this permission is not valid unless signed)

_____ _____

Parent/Guardian Signature Dated