



Anne Arundel Community College

101 College Parkway Arnold, Maryland 21012-1895 410 647-7100

Sport _____

Date _____

ACCIDENTAL INJURY WAIVER FORM

I, _____, do hereby acknowledge that I understand that there are inherent risks for possible injury while participating in an intercollegiate athletic program, and I accept full responsibility for that possibility. I further acknowledge that neither Anne Arundel Community College nor its agents or employees will be held responsible for any injuries or medical expenses that I might incur while participating in this intercollegiate athletic program.

I also acknowledge that Anne Arundel Community College will not be responsible for any medical or other costs that I might incur as a result of my participation in this program. I have been advised that it may be prudent for me to maintain my own health insurance policy or other appropriate policy that would cover any injuries that I may incur during my participation in this intercollegiate athletic program.

I also certify that I have no physical condition or injury that I have not disclosed which might affect my participation in this intercollegiate athletic program. I hereby give authorization to the Anne Arundel Community College athletic staff and/or medical consultants to evaluate and treat any injuries that may occur during my participation in the athletics program. I understand that the athletic trainer has the authority to remove me either temporarily or permanently from further participation in the program.

I hereby affirm that I have read and understand the terms and conditions of this Accidental Injury Waiver Form and agree to accept the terms and conditions.

Student's Signature: _____ Student's Name: _____
(PLEASE PRINT)

Social Security No: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Phone: _(_____) _____ Email: _____

Parent's/Guardian's Signature _____
(REQUIRED IF STUDENT IS UNDER 18 YEARS OF AGE)

EMERGENCY INFORMATION

1) Emergency Contact:

Name: _____ Relationship: _____

Home phone: (_____) _____ Work phone: (_____) _____

2) Emergency Contact - if first contact is unavailable:

Name: _____ Relationship: _____

Home phone: (_____) _____ Work phone: (_____) _____

INSURANCE INFORMATION

COMPANY NAME

POLICY # AND/OR GROUP ID#

PHONE NUMBER

ANNE ARUNDEL COMMUNITY COLLEGE

Physician's Statement and Medical Clearance Form

Student's physician must complete this form and return by mail or fax as soon as possible to address below. Student may not participate in program until this form has been provided.

TO: _____ Date: _____
Coach's Name and Office Location
101 College Parkway
Arnold MD 21012
Fax: _____
Phone: _____

RE: _____ Program: _____
Student/Patient Name

The above named student-athlete would like to participate in an intercollegiate athletic program, which requires aerobic, anaerobic and/or strengthening exercise of gradually increasing intensity.

I concur with her/his participation – with no restrictions.

I concur with her/his participation – if the activities are restricted as follows:

I certify that I have, on this date, examined this student-athlete and that on the basis of the examination requested by the college authorities and the student's medical history furnished to me, I have found no reason which would make it medically inadvisable for this student to participate in supervised athletic events and/or activities.

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ Phone: _____

I hereby grant my above physician permission to talk with the coach/athletic trainer and/or release any pertinent medical information from my medical records, which my physician believes, is medically necessary for the coach/athletic trainer to review for my participation in this athletic program. This authorization is valid for one year from the signed date and I understand that I may revoke this authorization in writing to the above named physician at any time with a copy of the revocation sent to the above named coach.

Student/Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(Required if student/patient is under 18 years of age.)