



**Release – Permission to Treat & Emergency Information**

Participant Name: \_\_\_\_\_  
Contact Address: \_\_\_\_\_  
Contact Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Emergency Contact Phone Number: \_\_\_\_\_

As athlete / custodial parent or court-appointed guardian of \_\_\_\_\_ (“athlete/child”). I do for athlete or both of child’s parents, for child and child’s heirs and successors, release Advantage Sports Complex Inc. and any of its agents or representatives (all of the foregoing collectively “ASC Inc.”) from all claims arising out of or connection with athlete/child’s participation in any ASC, Inc. program. I provide this release because I am mindful that athletics, physical training and competition can be a dangerous undertaking regardless of how careful or prudent any person, firm or facility might be. Further, I give permission to ASC Inc. to treat myself/child or arrange for medical care or treatment for child in any situation deemed reasonably necessary by ASC Inc. If circumstances permit, ASC Inc. shall attempt to communicate first via telephone with the following emergency contacts for athlete/child.

Primary Emergency Contact: \_\_\_\_\_ Secondary Emergency Contact: \_\_\_\_\_  
(Name and Relationship) (Telephone #) (Name and Relationship) (Telephone #)

In the event neither emergency contact can be reached or if the urgency of the situation requires immediate attention without prior telephone contact, ASC Inc. may arrange for medical treatment for the child at the expense of the parent or guardian signing this form. Health Insurance, PPO information for child is as follows:

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone :( ) \_\_\_\_\_

In order to seek appropriate medical care of treatment of child, please disclose the following:

Allergies: \_\_\_\_\_ (please specify or “none”)  
Heart disease or other: \_\_\_\_\_ (please specify or “none”)

Any other conditions, symptoms or disability which would or might affect medical care or treatment or participation in the ASC Inc. program: \_\_\_\_\_

Signature (Custodial parent or court appointed guardian)

(Date)

2800 N Interstate 35 East  
Carrollton, Texas 75007  
www.ascvb.com  
(817) 545 - 4551