



## APA Medical Waiver & Treatment Form

In consideration of my child's participation in an American Polocrosse Association (APA) activity, and the inherent risks of equine activity that may result in injury/harm requiring emergency medical treatment, I authorize the APA, its successors, or assigns, officials, officers, directors, employees, agents, and/or volunteers to obtain and release to any APA activity personnel; (including, but not limited to, organizers, instructors, coaches, managers, chaperons), and to any first aid and safety personnel, medical professionals, and treating medical facility, any information regarding my child's medical history, symptoms, treatment, exam results and / or diagnosis.

I have read this release and agree to it.

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Participant Name

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Participant Signature

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Parent or Legal Guardian Name

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Parent or Legal Guardian Signature

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Date