NZR AGE BAND EXCEPTIONAL CASE MEDICAL CERTIFICATE (Feb 25)

COMPLETED FORM TO BE SUBMITTED TO YOUR COMPETITION GOVERNING BODY'S PROVINCIAL UNON

Player Details (please print clearly)

Name:	**National Rugby ID:**
Club/School	**Provincial Union:**
Number of Years played:	**Proposed playing position:**
Weight:	**Height:**
Date of Birth:	**Requested Competition:**
Contact Phone No:	**E-mail:**

Parent/Legal Guardian (Consent required if player is less than 18 years old)

I confirm that:

a) I am the player or a parent or legal guardian of the above-mentioned player;

b) I have been provided with a copy of the NZR Age Band for Playing Policy.

c) I consent to my contact details being provided to an Assessing Coach for the purpose of the player undergoing a technical assessment (including for arranging a suitable time and day to undertake the assessment);

d) It has been explained to me that the aim of Age Band for Playing Policy is to facilitate inclusion so long as it is safe and for rugby participants with comparable physical development in conjunction with ability and/or experience to play with and against each other;

e) I understand that rugby is a contact sport, and, like all contact sports, players are exposed to a risk of injury. In addition to understanding these risks, I also agree, to the extent permitted by law, to waive my right to bring any claim for liability against any participant (including players, coaches, volunteers and administrators) and release all participants from any liability that may be incurred in connection with the player's participation in the requested or recommended age grade.

Name: **Signature:** **Date:**

Doctor

I confirm that:

a) I have been provided with a copy of the NZR Age Bands for Playing Policy here; and

b) The player is physically able to participate in a contact sport at the level proposed; and

c) I have provided relevant medical advice to the player and their legal guardian of any matter that they should consider in applying to play outside their recommended age bands.

Name:	**Medical Counsel Registration Number:**
Phone:	**Email:**
Signature:	**Date:**