(name of soccer club)

MEDICAL RELEASE FORM

PLEASE PRINT

As the parent/legal guardian of ________________________________, I request that in my absence the above-named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor.
I hereby acknowledge that I have full comprehensive accident insurance protecting my child against accident or injury that my child might encounter as a participant in this program. I further recognize that my child is participating at his or her own risk and with the signing of this document, I free __(name of soccer club)___, its directors, officials and volunteers from any liability should such an accident or injury occur.

PLAYERS'S DATE OF BIRTH: ___________________________

Known allergies or special conditions of this player, including any allergies to medicine: (please explain in detail)____
____
____

DATE OF LAST TETANUS SHOT: ____

Family Physician: ________________________________Phone: ( ) _____________________
Address: ____

Names of Parent/Guardian: ____
Address: ____
Phone: (H) ________________________(Cell)____________________ (W)_________________

Person to notify if parent/guardian is unavailable: ____________________________________
Phone : ____________________________________

If Child needs to be transported to Hospital, which hospital is your preferred choice:____

Insurance Carrier: ____________________________ Policy Number:____________________
Group Number: ___________________

Person responsible for charges (if different from above): _____________________________
Address: ____
Phone: ____

Signature of Parent/Guardian: ____________________________________Date:_____________