



MEDICAL RELEASE FORM

As the parent/legal guardian of _____, I request that in my absence the above player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentist, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedure, treatment and operative procedures, and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above named player.

Date of Players Birth _____ Date of last Tetanus _____
Mo. Day Year Mo. Day Year

Known allergies of this player, including any allergies to medicine _____

Any other medical problems which should be noted _____

Family Physician _____ Phone _____

Name of Parent/Guardian _____
Address _____
City/State/Zip _____
Home Phone _____ Work Phone _____

Person responsible for charges (if different than above) _____
Address _____
City/State/Zip _____
Home Phone _____ Work Phone _____

Person to notify if Parent/Guardian is unavailable _____
Home Phone _____ Work Phone _____

Insurance Carrier _____ Policy # _____

I understand that soccer is a competitive sport and I will not hold Loyalhanna United Soccer Club or its staff and volunteers or associated organization responsible for any injury of personal belonging.

Signature of Parent/Guardian _____ Date _____