

MEDICAL RELEASE FORM

As the parent/legal guardian of _____, I request that in my absence, if needed, 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 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.

Recognizing the possibility of injury associated with soccer and in consideration for the USSF/USYSA and its affiliates, I hereby release, discharge and/or otherwise indemnify the USSF/USYSA, its affiliated organizations and sponsors, their employees and personnel, including the owners of the fields and facilities utilized for the League/Tournament contents against any claim by or on behalf of the player as a result of the player's participation.

Date of Players Birth ____/____/____

Date of Last Tetanus Shot ____/____/____

Known allergies of the player, including any allergies to medicine. _____

Any other medical problems which should be noted. _____

Name of Parent/Guardian _____

Address _____

City/State/Zip _____

Phone _____

Person to notify if parent/guardian is unavailable _____

Phone _____

Family Physician _____ Phone (____) _____

Insurance Carrier _____ Policy Number _____

Signature of Parent/Guardian _____