



# Medical Release Form

Player Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Mother: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

Father: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy/Group Number: \_\_\_\_\_

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Known Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_ Date of last Tetanus shot: \_\_\_\_\_

Does player wear eyeglasses or contact lenses? D Yes Y No

Emergency Contacts to call if parents are unavailable (please list weekend/evening numbers):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Recognizing the possibility of physical injury associated with soccer and in consideration for GYSA, USYSA/USSF and its affiliates accepting the registrant for its soccer programs and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify the GYSA, USYSA/USSF, its affiliated organizations and sponsors, their employees and associated personnel, including the owners of the fields and facilities utilized for the Programs against any claim by or on behalf of the registrant as a result of the registrant's participating in the Programs and/or being transported to or from the same, which transportation I hereby authorized. My child has received a physical examination by a physician and has been found physically capable of participating in the Programs. Therefore, I grant CCSA Cannons Soccer Club and its representative permission to act as my surrogate for my child in the area of obtaining medical treatment by a doctor of medicine or dentistry. I also assume the financial responsibility for any medical treatment for my child.

Signature (Parent/Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Subscribed and sworn before me, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public