



Soccer Training Camp

Player Medical Release Form

Player's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY INFORMATION

Father's Name: _____ Cell Phone: _____ Work Phone: _____

Mother's Name: _____ Cell Phone: _____ Work Phone: _____

In an emergency, when parents cannot be reached, please contact:

Name: _____ Cell Phone: _____ Work Phone: _____

Name: _____ Cell Phone: _____ Work Phone: _____

Allergies: _____

Other Medical Conditions: _____

Player's Physician: _____ Business Phone: _____

Medical and/or Hospital Insurance Company: _____

Policy Holder: _____ Policy #: _____ Group #: _____

PARENT’S APPROVAL AND MEDICAL RELEASE

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, dentist, 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.

Signature of Parent/Guardian

Date