



Medical Release Form

I hereby give permission for any and all medical attention necessary to be administered to my

child (PLAYER'S NAME): _____ in the event of an accident, injury, sickness, etc. Recognizing the possibility of physical injury and in consideration of USSF and its affiliates accepting the registrant for its program and activities (the "Programs"), I, the undersigned parent/guardian of the registrant, a minor, do hereby release, discharge and/or otherwise indemnify the USSF, its affiliated organizations and sponsors, the Spirit United Soccer Club and its affiliated organizations, officers, coaches, referees, managers, board members, tournament hosts and their officials, their employees and associated personnel, including the owners of the fields and facilities utilized for the Programs and/or social events, against any claims by or on behalf of the above named player as a result of my son's/daughter's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize by the officer, coach or agent(s) of the Spirit United Soccer Club.

My son/daughter has received a physical examination by a physician and has been found physically capable of participating in the Programs. I, the parent/legal guardian of the above-named player, hereby give my consent to have an athletic trainer and/or doctor of medicine or dentistry provide my son/daughter with medical assistance and/or treatment and agree to be responsible financially for the reasonable cost of each assistance and/or treatment. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of my dependent.

Player's Date of Birth ___/___/___ Known Allergies of this Player, including allergies to medicines: _____

Player's other medical conditions: _____

Player's Physician _____ Phone: _____

Father's Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Mother's Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Player's Address is: _____

(City, State, Zip Code)

Person to notify if parent/guardian is unavailable: _____

Home Phone: _____ Work Phone: _____

Insurance Carrier: _____ Policy #: _____ Group #: _____

Carrier Phone: _____ Policy Holder: _____

PLEASE COPY BOTH SIDES OF YOUR MEDICAL INSURANCE CARD & ATTACH TO THIS FORM

Signature of Parent/Guardian: _____ Date: _____