SOCCER MEDICAL RELEASE FORM

THIS FORM MUST BE FILLED OUT COMPLETELY

I hereby give my permission for any and all medical attention necessary to be administered to my child, _____ (INSERT CHILD'S NAME).

In the event of an accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted, this release is effective for a period of one year from the date given below. I also assume the responsibility for the payment of any such treatment, including, but not limited to transportation for required treatment.

Parent/Guardian:

Address: _____City/State/Zip: _____

home phone: _____work phone: _____ cell phone: _____

Name of Insurance Company: _____Agent: _____

Policy Number: _____ Type: _____

In case I cannot be reached, any of the following people are designated to act on my behalf:

1. Memorial Camp Administrative Director
2. Memorial Camp Soccer Director

In case I cannot be reached, please call:

Our Physician's Name: _____ Phone: _____

Address: _____City/State/Zip: _____

Hospital: _____

Known Allergies: _____

Known Disabilities: _____

Other Important Medical Information: _____

_____

_____

I also understand that my child cannot attend the Dave Prout Memorial Goalie Camp with a suspected concussion. If a concussion is suspected, a waiver from a doctor is required to participate.

_____ _____

Signature of Parent/Guardian Date