

Medical Release

Player:	Home Phone:	
Address:	City:	Zip:
Mother:	Mother's Daytime Phone:	
Father:	Father's Daytime Phone:	
Insurance Company:	Insurance Policy Number:	
Person to Contact: (Other than parent)	Phone:	
Player's Doctor:	Doctor's Phone:	

1. _____ Coach
2. _____ Coach
3. The Director of a tournament my child plays in
4. A Soccer Club Board Member

The people listed above have my permission to authorize medical treatment of the above named player.

Signature of parent or legal guardian
This permission for treatment expires on 8/31/2014