MSYSA SOCCER MEDICAL RELEASE

PLEASE PRINT

I hereby give my permission for any and all medical attention necessary to be administered to
My child (first) _____ (last)_____
In the event of 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: _____ **RELATIONSHIP: _____**

CITY _____ STATE: _____ ZIP: _____

HOME PHONE: _____ OFFICE PHONE: _____CELL: _____

PAGER: _____ OTHER_____

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. COACH: _____
2. ASSISTANT COACH/MANAGER: _____
3. A League Representative where my child is playing.
4. Any tournament representative where my child is participating in a USYSA – sanctioned Tournament
5. Team parent: _____

In case I cannot be reached, please call _____ at _____

OUR PHYSICIAN'S NAME: _____

ADDRESS: _____

CITY: _____ , MI. ZIP: _____

PHONE NUMBER: _____ HOSPITAL: _____

KNOWN ALLERGIES: _____

KNOWN DISABILITIES: _____

OTHER IMPORTANT MEDICAL INFORMATION:

_____

Signature of Parent/Guardian: _____ Date: _____

Subscribe and sworn to before me, this _____ day of _____

NOTARY PUBLIC: **My commission expires:**