SOMERSET WEST SOCCER CLUB

MEDICAL RELEASE FORM

As the parent/legal guardian of _____, 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, dentists, 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 also authorize the hospital of medical facility to dispose of any specimen or tissue taken from the
above-named player.

Date of Player's Birth ____/____/____ Date of last Tetanus Booster ____/____/____
Month Day Year Month Day Year

Known allergies of this player, including any allergies to medicine:

_____

Any other medical problems that should be noted: _____

_____

Family Physician _____ Phone _____

Name of Parent/Guardian: _____

_____
Address/City/State/Zip

Phone _____H _____ W _____Cell

Person responsible for charges (if different from above):_____

_____
Address/City/State/Zip

Phone _____H _____ W _____Cell

Person to notify if parent/guardian is unavailable: _____

Phone _____H _____ W _____Cell

Insurance Carrier _____Policy Number _____

Concussion Receipt: By signing this form I acknowledge that I have received a copy of the Concussion Fact Sheet. If my child is 12 or older, I also acknowledge that I have reviewed the Concussion Fact Sheet with my child.

Signature of Parent/Guardian: _____

Date: _____