

CAPITAL AREA SOCCER LEAGUE MEDICAL RELEASE FORM

I hereby give my permission for any and all medical attention necessary to be administered to my child in the event of an accident, injury, sickness etc., under the direction of the people listed below until such time as I may be contacted. This release is effective for the time which my child is participating in "Capital Area Soccer League" games, team practice sessions and any tournaments for the 20____ / 20____ soccer seasons. I also hereby assume the responsibility for payment of any such treatments.

My Childs Name Is _____

Father/Guardian Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address: _____
(Street) (City) (State) (Zip Code)

Mother/Guardian Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address: _____
(Street) (City) (State) (Zip Code)

Health Insurance Company _____ Policy # _____

Doctor Preference _____ Phone # _____

Hospital Preference _____

Emergency Phone # _____ Contact _____

In the event parents can not be contacted, the following people are designated to seek medical attention for my child.

Coaches Name: _____ Coaches Name _____

Name _____ Relationship _____

Home Phone: _____ Work Phone: _____

Name _____ Relationship _____

Home Phone: _____ Work Phone: _____

Signature of Parent or Guardian _____ Date _____

Subscribed and sworn before me this date: _____, 20____

Signature of Notary Public _____