

TURNER VALLEY SHOWDOWN – PA WEST SOCCER ASSOCIATION

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 authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

Date of Players Birth: ____/____/____ Date of last Tetanus Booster: ____/____/____

Known allergies of this player, including any allergies to medicine or any other medical problem in which should be noted: _____

Family Physician: _____ Phone: (____) _____ - _____

Name of Parent/Guardian: _____

Address: _____

City/State/Zip: _____

Phone: (H) (____) _____ - _____ (W) (____) _____ - _____ FAX (____) _____ - _____

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

Address: _____

City/State/Zip: _____

Phone: (H) (____) _____ - _____ (W) (____) _____ - _____ FAX (____) _____ - _____

Person to notify if parent/guardian if unavailable: _____

Phone: (H) (____) _____ - _____ (W) (____) _____ - _____ FAX (____) _____ - _____

Insurance Carrier: _____ Policy Number: _____

Signature of Parent/Guardian: _____