



NORTH TACOMA SOCCER CLUB

MEDICAL RELEASE FORM

(This form must be in the coach's possession at all practices, games and tournaments for all rostered players)

As the parent/legal guardian of _____, I request that in my absence the above named player be admitted to any hospital or local medical facility for diagnosis and treatment. I request and authorized 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, pervasive 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 Player's Birth ___/___/___ Date of Last Tetanus Booster ___/___/___ Known allergies of this player, including any allergies to medicine

Family Physician _____ Phone (____) _____

Name of Parent/Guardian _____

Address _____

City/State/Zip _____

Phone H _____ W _____ FAX _____ Cell _____

Person responsible for charges (if different from above) _____

Phone H _____ W _____ FAX _____ Cell _____

Person to notify if parent/guardian is unavailable _____

Phone H _____ W _____ FAX _____ Cell _____

Insurance Carrier _____ Policy Number _____

Signature of Parent/Guardian _____ Date _____