NORTHPORT COW HARBOR UNITED SOCCER CLUB
MEDICAL RELEASE FORM

AS PARENT OR LEGAL GUARDIAN OF (NAME 0F PLAYER) _____, I REQUEST IN MY ABSENCE, THE ABOVE NAMED PLAYER BE ADMITTED TO ANY HOSPITAL OR MEDICAL FACILITY FOR DIAGNOSIS AND TREATMENT AND TO BE TRANSPORTED TO SUCH FACILITIES. 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 PLAYER. I HAVE NOT BEEN GIVEN A GUARANTEE AS TO THE RESULTS OF THE EXAMINATION OR TREATMENT.

I ACKNOWLEDGE THAT THE PLAYER PLAYING WITH OR FOR ANY NORTHPORT COW HARBOR UNITED SOCCER CLUB TEAM IS WHOLLY VOLUNTARY ON THE PART OF THE PLAYER ANY MYSELF AND FURTHER I ASSUME THE RESPONSIBILITY FOR ANY AND ALL PAYMENTS OF THE MEDICAL OR DENTAL PROCEDURES OR TREATMENT AND THE EMERGENCY TRANSPORTATION REQUIRED IN THE EVENT OF AN ACCIDENT, INJURY, SICKNESS, ETC.

BIRTH DATE: _____ DATE OF LAST TETANUS BOOSTER: _____

KNOWN ALLERGIES (INCLUDE MEDICINE): _____

KNOWN MEDICAL PROBLEMS: _____

PHYSICIAN: _____ DENTIST: _____

ADDRESS: _____ _____

_____ _____

PHONE: (____) _____ (____) _____

PARENT/GUARDIAN: _____ PHONE: (____) _____
(home)

ADDRESS: _____

_____ (____) _____
(work)

PERSON RESPONSIBLE FOR PAYMENT OF BILLS AND FEES:(if different from above)

NAME: _____ PHONE: (____) _____
(home)

ADDRESS: _____

_____ (____) _____
(work)

PERSON TO NOTIFY IF PARENT/GUARDIAN IS UNAVAILABLE:

_____ _____ _____
(name) (home phone) (work phone)

_____ _____ _____
(name) (home phone) (work phone)

INSURANCE CARRIER: _____ POLICY: _____

SIGNATURE OF PARENT/ GUARDIAN: _____ DATE: _____

TEAM: _____ AGE GROUP: _____

COACH: _____ PHONE : _____

ASST COACH: _____ PHONE: _____