



Fairport 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 any x-ray treatment of the above-named 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. I accept full financial responsibility for any such treatment. I also give permission for any transportation required to a medical facility and assume full financial responsibility for said transportation.

Date of Player's birth: ___/___/___ Date of last Tetanus Booster: ___/___/___
month day year month day year

Known allergies of this player, including allergies to medicines: _____

Other medical problems or activity restrictions: _____

Family Physician: _____ Phone: _____

Name of Parents / Legal Guardians: _____

Address: _____
address city state zip

Father's Phone: _____
home work cell

Mother's Phone: _____
home work cell

Person to notify if Parent/Guardian is unavailable: _____

Alt Contact: _____
home work cell

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

Address: _____
address city state zip

Telephone: _____
home work cell

Insurance carrier: _____ Subscriber: _____

Medical Insurance Policy Number: _____

Signature of Parent/Guardian: _____ Date: ___/___/___
month day year