Medical Release Form

Athlete's Name _____
Birthdate _____
Known Allergies _____
_____
Medical Conditions _____
_____

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Birthdate _____
Known Allergies _____
_____
Medical Conditions _____
_____

Family Insurance Information:
Primary Medical Insurance Company _____
Policy Number _____
Group or Type Number _____
Primary Physician _____ Phone Number _____

Contact Information:
Parent or Legal Guardian _____ Phone Number _____
Parent or Legal Guardian _____ Phone Number _____

In my absence, any of the following people, in the order identified below, are designated to act on my behalf:

1. Secondary Contact Name _____ Phone Number _____
2. Coach Catherine Marshall – Reaching Goals Soccer Academy Owner / Head Coach

In my absence, I give my consent and permission for medical transportation and to have a paramedic and/or duly licensed Doctor of Medicine and/or duly licenses Doctor of Dentistry provide my child or legal guardian, a minor identified as "Athlete's Name" above, with any and all medical assistance or treatment deemed necessary in the event of an accident, injury, or sudden illness. Further, I authorize admission to any hospital or medical facility for such treatment, including diagnostic procedures performed by licensed technicians or nurses. I authorize the hospital or medical facility to dispose of any specimens or tissue as appropriate. This release is effective until my arrival and it is revoked by me. I agree to be responsible financially for the cost of each transportation, assistance or treatment.

Signature _____ Date _____