

# Medical Release

Player:	Home Phone:	
Address:	City:	Zip:
Mother:	Mother's Daytime Phone:	
Father:	Father's Daytime Phone:	
Insurance Company:	Insurance Policy Number:	
Person to Contact: (Other than parent)	Phone:	
Player's Doctor:	Doctor's Phone:	

1. \_\_\_\_\_ Coach
2. \_\_\_\_\_ Coach
3. The Director of a tournament my child plays in
4. A Soccer Club Board Member

The people listed above have my permission to authorize medical treatment of the above named player.

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Signature of parent or legal guardian  
This permission for treatment expires on 8/31/2012