



TEAM AMERICA FOOTBALL CLUB Medical Release Form

Players Name: _____

Address: _____
(Street)

(City) (State) (Zip)

Date of Birth: _____ Gender: M F (Circle One)
Team Name: Team America Team Age: _____

EMERGENCY INFORMATION:

Father's Name: _____ Telephone: Home _____
Mother's Name: _____ Telephone: Home _____

In an emergency when parents cannot be reached, please contact:
Name: _____ Telephone _____ Relationship _____

Allergies: _____
Other Medical Conditions: _____

As the Parent/Guardian of the minor child listed above, I hereby authorize and empower the coaches or any designated official of the soccer team to consent to any X-ray examination, anesthetic, medical, or surgical diagnosis or treatment, and hospital care to be rendered to the minor child under the general or special supervision and on the advise of a duly licensed physician or surgeon. The power shall be in effect during any period that my child is away from their residence in connection with the activities of the soccer team. I agree to be responsible financially for the reasonable cost of such assistance and/or treatment.

Medical Insurance Carrier Signature of Parent/Guardian

Policy Number Date

Subscribed and sworn to before me this _____ day of _____, 19 _____.

Notary Public

Seal My Commission Expires: _____