

# Chambersburg Youth Soccer Association Medical Release Form

This is to certify that I/We \_\_\_\_\_, the parents or legal guardian of the person listed below, do constitute and appoint Chambersburg Youth Soccer Association and their representatives the power to authorize and consent to the administration of any medical treatment deemed necessary by an attending physician on the below named minor. I/We also assume the financial responsibility for any such treatment.  
I/We hereby release Chambersburg Youth Soccer Association and its representatives from any claim by or on behalf of the minor named below.

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Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date of last Tetanus Booster \_\_\_\_\_

Allergies \_\_\_\_\_

Medical History \_\_\_\_\_

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Current Medications \_\_\_\_\_

Family Physician \_\_\_\_\_ phone: \_\_\_\_\_

Insurance Company \_\_\_\_\_

Policy/Group Number \_\_\_\_\_

Name of Insured \_\_\_\_\_

Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_

## Emergency Contact Information

Name \_\_\_\_\_

Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_

Signature of Guardian \_\_\_\_\_ Date \_\_\_\_\_