

## PARENT/GUARDIAN CONSENT AND PLAYER MEDICAL RELEASE FORM

Player's Name:	Date of Birth:	G	ender:	
Address:	City:	State:	Zip:	
EMERGENCY INFORMATION				
Father's Name:	Home Phone:	Work Phone:		
Mother's Name:	Home Phone:	Work Phone:		
In an emergency, when parents cannot be	e reached, please contact:			
Name:	Home Phone:	Work Phone:		
Name:	Home Phone:	Work Phone:		
Allergies:				
Other Medical Conditions:				
Player's Physician:	Home Phone:	Work Pho	one:	
Medical and/or Hospital Insurance Company:		Phone: _	Phone:	
Policy Holder:	Policy #:	Group #: _		
PLEASE COPY BOTH SIDES OF YOUR HEALTH INSURANCE CARD AND ATTACH TO THIS FORM  PARENT/GUARDIAN CONSENT AND MEDICAL RELEASE  Recognizing the possibility of injury or illness, and in consideration for US Youth Soccer and members of US Youth Soccer accepting my son/daughter as a player in the soccer programs and activities of US Youth Soccer				
and its members (the "Programs"), I con hereby release, discharge, and otherwise their employees, associated personnel, a the Programs, against any claim by or on participation in the Programs and/or bettransportation of my son/daughter to or	sent to my son/daughter pare indemnify US Youth Soccer, nd volunteers, including the behalf of my player son/dauing transported to or from th	ticipating in the Pro its member organiz owner of fields and ighter as a result of	ograms. Further, I zations and sponsors, facilities utilized for my son's/daughter's	
My player son/daughter has received a physically capable of participating in the in conjunction with this release and attached addition to what is specified above, that Programs. I give my consent to have an a son/daughter with medical assistance ar reasonable cost of any such assistance and the solution of the solut	sport of soccer. I have proviched hereto, setting forth any my child has or that may impathletic trainer and/or licens and/or treatment and agree to	ded written notice, y specific issue, con- act my child's parti ed medical doctor o	which is submitted dition, or ailment, in cipation in the or dentist provide my	
Signature of Parent/Guardian		Date		