

CCYSA

Clarke County Youth Soccer Association

P.O. Box 720 Berryville, Virginia 22611 (540) 955-9002

Medical Release Form

As the parent/Guardian of _____, I request that my Absence of the above named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentist and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and X-ray treatment of the above minor. I have not been given a guarantee as to the results of the examination or treatment. I authorize the hospital or facility to dispose of any specimen or tissue taken from the above named player.

Date of Player's Birth _____ Date of last Tetanus Booster _____

Known allergies of this player, including any allergies to medicine _____

Any other medical problems which should be noted _____

Family Physician _____ Phone _____

Name of Parent/Guardian _____

Address _____

Phone _____ H _____ W _____ C _____

Person responsible for charges (if different from above) _____

Address _____

Phone _____ H _____ W _____ C _____

Person to notify if Parent/Guardian is unavailable _____

Phone _____ H _____ W _____ C _____

Insurance Carrier _____ Policy # _____

Signature of Parent/Guardian _____ Date _____