TAUGHANNOCK SOCCER CLUB, INC.

MEDICAL RELEASE FORM

As the parent/legal guardian of ______________________________, I request that in my absence the above-named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, 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.

Date of Player's Birth____/____/______ Date of last Tetanus Booster____/____/______

Known allergies of this player, including any allergies to medicine:____________________

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Any other medical problems that should be noted: ______________________________

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Family Physician______________________________Phone (_____)_____-__________

Name of Parent/Guardian____

Address____

City/State/Zip____

Phone________________________ (Home) ________________________ (Work)

Email ________________________

Person responsible for charges (if different from above)__________________________

Address____

City/State/Zip____

Phone________________________ (Home) ________________________ (Work)

Email ______________________________

Person to notify if parent/guardian is unavailable____________________________________

Relationship ____________________________________

Phone________________________ (Home) ________________________ (Work)

Insurance Carrier__________________________________Policy Number__________________

Signature of Parent/Guardian

X____ Date ______________________