TEAM AMERICA FC
MEDICAL RELEASE FORM

PLAYERS NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

TEAM NAME: Team America_____ TEAM AGE:_____ ☐ MALE ☐ FEMALE

ALLERGIES:_____

OTHER MEDICAL CONDITIONS:_____

EMERGENCY INFORMATION:

FATHER'S NAME:_____ CELL /BUS TEL.:_____

MOTHER'S NAME:_____ CELL /BUS TEL.:_____

In an emergency when parents cannot be reached, please contact:

NAME:_____ CELL /BUS TEL.:_____ RELATIONSHIP_____

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 _____, 20_____.

_____

NOTARY PUBLIC

SEAL: MY COMMISSION EXPIRES:_____