Louisa Area Soccer Association

MEDICAL RELEASE FORM

Players Name: _____ Date of Birth: _____
Address: _____
City:_____ State:_____ Zip Code:_____
Phone Number: _____
Mother's Name:_____ Father's Name:_____

If parent/guardian are not present at a game or practice and cannot be reached, who should be contacted in case of emergency?

Name: _____ Phone Number: _____
Relationship: _____

Family Doctor: _____ Phone Number: _____
Family Dentist: _____ Phone Number: _____
Hospital of Preference: _____

Name of Insurance: _____
Policy Number/Type of Plan: _____

Has the player had any major injuries/illnesses in the last few years? _____
If yes, please list:_____
_____

Does the player have any recurring illnesses/ allergies/ reactions we should be aware of? _____
If yes, please list:_____
_____

As parent/ guardian of the above mentioned player, I hereby give my consent for emergency medical care prescribed by a duly licensed doctor of medicine or doctor of dentistry. This care may be given under what ever conditions are necessary to preserve life, limb, or well being of my dependent. I will not hold the Louisa Area Soccer Association or any other volunteer responsible in case of an accident or injury as a result of my child's participation. I understand the risks involved with the soccer and know that my child is physically able to participate.

_____ _____
Signature of Parent / Guardian Date