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 in the event of an accident, injury, sickness or other medical emergency. 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. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

This instrument of consent to authorize medical attention shall be in effect as of the date given below. This shall remain in force only until such time as I am contacted and able to assume such responsibility for the care of my child. I will be responsible for any and all fees and/or costs incurred as a result of this authorization.

In signing this document, I also understand that any and all personnel associated with Carmel United Soccer Club shall not be held liable for any injury whatsoever my child may sustain in the activities thereof.

In the event that I cannot be reached, or in my absence, I have designated the following individual(s) to make the necessary decisions on my behalf:

____ ____________________ _____________________ _______________
Name Relationship Home Phone Work Phone Cell Phone

____ ____________________ _____________________ _______________
Name Relationship Home Phone Work Phone Cell Phone

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____ ____________________ ___________________________________
PLAYERS NAME DATE OF BIRTH DATE OF LAST TETANUS BOOSTER

ANY KNOWN ALLERGIES, INCLUDING MEDICINES:____

ANY OTHER MEDICAL CONDITIONS WHICH SHOULD BE NOTED:

____

****

NAME OF PARENT/GUARDIAN____

ADDRESS____

CITY/STATE/ZIP____

HOME PHONE_______________________WORK PHONE_______________________CELL_________________________________

FAMILY PHYSICIAN:_______________________________________PH#____

INSURANCE CARRIER_______________________________________POLICY NUMBER____________________________________

SIGNATURE OF PARENT/GUARDIAN____

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IN THE STATE OF INDIANA, ____________________________COUNTY, THIS DOCUMENT HAS BEEN SWORN TO, AND

SUBSCRIBED BEFORE ME ON THE ___________ DAY OF_______________________, 20_________

____
NOTARY PUBLIC FOR THE STATE OF INDIANA

____
PRINTED NAME:

RESIDENT OF ________________________COUNTY, INDIANA

MY COMMISSION EXPIRES:________________________