Buffalo Soccer Club

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 nurse, 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.

Date of Players Birth_____/_____/_____ Date of last Tetanus Booster_____/_____/_____
Month Day Year Month Day Year

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 _____

City/State/Zip _____

Home _____ Work _____ Cell _____

Person responsible for charges (if different from above) _____

Address _____

City/State/Zip _____

Home _____ Work _____ Cell _____

Person to notify if parent/guardian is unavailable _____

Home _____ Work _____ Cell _____

I

Insurance Carrier _____ Policy Number _____

Signature of Parent/Guardian _____ Date _____

JURAT

STATE OF _____

COUNTY OF _____

Sworn to and subscribed before me on the _____ day of _____, 20_____

_____

Notary Public in and for the State of _____

Commission expires _____