

## MEDICAL RELEASE FORM

I hereby give my permission for any and all necessary medical attention to be administered to my child, \_\_\_\_\_ in the event of an accident, injury, or sickness, under the direction of the following persons, until such time that I may be contacted. I also assume the responsibility for payment of any needed treatment. This release is in effect for a period of one year from the date below.

<b>Parent/Guardian Name:</b>	
<b>Address Line 1:</b>	
<b>Address Line 2:</b>	
<b>Home Phone:</b>	
<b>Work Phone:</b>	
<b>Insurance Company:</b>	
<b>Policy Number:</b>	

In the event I am unable to be contacted, the following persons are designated to act in my behalf:

	Name	Phone Number
<b>Coach:</b>		
<b>Manager:</b>		
<b>Other Person:</b>		
<b>Any Tournament Rep at Tournament Location:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Medical information:

<b>Family Physician:</b>	
<b>Physician Address:</b>	
<b>Physician Phone #:</b>	
<b>Date of Last Tetanus Booster:</b>	
<b>Known Allergies: (include allergies to medications)</b>	
<b>Medications Child is Taking (include long-term medications, allergy shots, etc...)</b>	
<b>Any Medical Problems Which Should Be Noted:</b>	

### PARENT'S APPROVAL AND MEDICAL RELEASE

Recognizing the possibility of physical injury associated with soccer and in consideration for VAFC and its affiliates accepting the registrant for its soccer programs and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify VAFC, its affiliated organizations and sponsors, their employees and associated personnel, including the owner of fields and facilities utilized for the Programs, against any claim by or on behalf of the registrant as a result of the registrant's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize.

My son/daughter has received a physical examination by a physician and has been found physically capable of participating in the Programs. I hereby give my consent to have an athletic trainer and/or doctor of medicine or dentistry provide my son/daughter with medical assistance and/or treatment, and agree to be responsible financially for the reasonable cost of each assistance and/or treatment.

**SIGNATURE (Parent/Guardian)** \_\_\_\_\_

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

Signed: \_\_\_\_\_

My commission expires: \_\_\_\_\_

