



MEDICAL RELEASE – DONEGAL YOUTH SOCCER

Team Name: _____ **Age Group:** _____

I hereby give my permission for any and all medical attention necessary that will be administered to my child. (NAME) _____ in the event of an accident, injury, sickness, etc. under the direction of the soccer coaches listed below, until I may be contacted. I also hereby assume the responsibility for payment of such treatment.

MY ADDRESS IS: _____:

HOME PHONE: _____

HEALTH INSURANCE COMPANY: _____

INSURANCE POLICY NUMBER: _____

OUR PHYSICIAN IS: _____

PHYSICIAN ADDRESS: _____

PHYSICIAN PHONE: _____

KNOWN ALLERGIES: _____

OTHER VITAL INFORMATION: _____

In case I cannot be reached, either of the following coaches are designated:

COACH: _____ PHONE: _____

COACH: _____ PHONE: _____

(PARENT OR GUARDIAN)

SIGNATURE: _____

PRINTED NAME: _____

DATE: _____