



# SPENCERPORT Soccer Club

P.O Box 210 Spencerport, NY 14559

## Spencerport Soccer Medical Release Form

Player: \_\_\_\_\_ Team: \_\_\_\_\_ Age \_\_\_\_\_ Group: \_\_\_\_\_

D.O.B: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_

Street: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Telephone: \_\_\_\_\_

In case a parent/guardian cannot be reached in the event of an emergency, the following is designated to act on my behalf:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home #: \_\_\_\_\_ Work: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Known medical problems and allergies: \_\_\_\_\_

I hereby give permission for any and all medical treatment necessary for my child in the event of an injury/accident under the discretion of medical personnel until I can be notified. This medical information form is for the Spencerport Soccer Club. I assume all responsibility for payment of such treatments. I release all persons associated with Spencerport Soccer Club and affiliated clubs from any and all legal responsibilities.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_