



SACHEM YOUTH SOCCER LEAGUE



Medical Release Form

Player's Name: _____ U.S. Citizen: Yes _____ No _____

Address: _____

City: _____ State: _____ Zip Code: _____

Birth Date: _____ Sex: _____ Social Security Number: _____

Parents: _____ E-Mail: _____

Home Phone: (____) _____ Dad's Work Phone: (____) _____

Cell / Beeper: (____) _____ Mom's Work Phone: (____) _____

Emergency Contact Information: (Other Than Parent / Guardian)

Name: _____ Phone: (____) _____

Relationship: _____ Cell / Beeper: (____) _____

Primary Medical Insurance Company: _____

Policy Number: _____

Physician's Name: _____

Address: _____ Phone: (____) _____

City: _____ State: _____ Zip Code: _____

Known Allergies or Other Pertinent Medical Information: _____

I hereby give my permission for any and all medical attention necessary to be administered to my child, listed above, in the event of an accident, injury, sickness, etc. under the direction of the person(s) listed below, until such time as I may be contacted. I also hereby, assume the financial responsibility for payment of any and all medical treatment to my child, listed above.

Therefore, I grant _____

and / or _____

authorization to act as a surrogate parent to my child, listed above, in the area of obtaining medical treatment by a doctor of medicine or dentistry. This release is in effect for a period of one year from the date given below.

Signature of Parent / Guardian: _____ Date: _____

Subscribed and sworn to me this _____ day of _____, 20____

Signature: _____

Notary Public

My Commission Expires: _____

NOTARY PUBLIC STAMP