



Freestate Soccer Alliance, Inc

P.O. Box 2093
Bowie, Maryland 20718

Medical Release Form

I hereby give my permission for any and all medical attention necessary to be administered to my child _____, in the event of an accident, sickness, etc., under the direction of the persons listed below, until such time as I may be contacted. In my absence I request the above-named player to 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 such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. This release is effective until such time as revoked by me. I also hereby assume responsibility for the payment of any such treatment.

Date of Player's Birth (mm/dd/yy) ___/___/___ Date of Last Tetanus Booster (mm/dd/yy)___/___/___

Known allergies, including medicine _____.

Any other medical problems to be noted _____.

Family Physician _____ Phone (____) ____-____

In case I cannot be reached, any of the following person(s) is authorized to act in my behalf :

1. _____, Coach 2. _____ Asst. Coach/Manager

3. A league or FREESTATE Soccer Alliance official/representative/tournament official/representative where my child is playing.

Name of Parent/Guardian _____

Address _____.

Phone (____) ____-____ (H) Phone (____) ____-____ (W) Phone (____) ____-____ (Fax)

Person to Notify if parent/guardian is unavailable _____

Phone (____) ____-____ (H) Phone (____) ____-____ (W) Phone (____) ____-____ (Fax)

Insurance Carrier _____ Policy Number _____

Signature or Parent/Guardian _____

Subscribed and sworn (affirmed) before me, this _____ day of _____ 19____

My commission expires _____/_____/_____
Month Day Year Notary Public

State of _____ County of _____