



1015 Hilltop Court Leesport, PA 19533

## MEDICAL RELEASE FORM

### CONTACT INFORMATION

Players Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

*In an emergency when parents cannot be reached, please contact:*

Contact Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

### MEDICAL INFORMATION

Allergies: \_\_\_\_\_

Other Medical Conditions: \_\_\_\_\_

Player's Physician: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_

Medical and/or Hospital Insurance Company: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Policy Number: \_\_\_\_\_

#### **Parent's Approval and Medical Release**

Recognizing the possibility of physical injury associated with soccer and in consideration for the USSF/USYSA and its affiliates accepting the registrant for its soccer program and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify the USSF/USYSA, Berks Soccer Academy, its affiliated organizations and sponsors, their employees and associated personnel, including the owners 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. I understand that medical insurance is not the responsibility of Berks Soccer Academy, and that primary insurance coverage is my responsibility.

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 such assistance and/or treatment.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date