



Parent/Guardian Consent and Player Medical Release Form

Player's Name: _____ DOB: _____ Gender: _____
Address: _____ City: _____ State: _____ Zip: _____

Emergency Information

Parent/Guardian
Name: _____ Phone: _____ Cell: _____

Parent/Guardian
Name: _____ Phone: _____ Cell: _____

In an Emergency, when parents/guardians cannot be reached, please contact:

Name: _____ Phone: _____

Allergies: _____

Other Medical Conditions: _____

Player's Physician: _____ Office Phone: _____

Medical and/or Hospital Insurance Company: _____

Policy Holder: _____ Policy #: _____ Group #: _____

Parent/Guardian Consent and Medical Release

Recognizing the possibility of Injury or Illness and in consideration for US Youth Futsal and members of Elite 1 Futsal Academy and US Youth Futsal accepting my son/daughter as a player in the Futsal Programs and Activities of Elite 1 Futsal Academy and its members (the programs), I consent to my son/daughter participating in the Programs. Further, I hereby release, discharge, and otherwise indemnify Elite 1 Futsal Academy and US Youth Futsal its members, organizations and sponsors, their employees, associated personnel, and volunteers, including the owner of fields, facilities utilized for the Programs, against any claim by or on behalf of my player, son/daughter as a result of my son's/daughter's participation in the Programs and/or being transported to or from the Programs. I hereby authorize the transportation of my son/daughter to or from the Programs.

My player son/daughter has received a yearly well child checkup/physical examination by a licensed medical doctor and has been found physically capable of participating in the sport of Futsal. I have provided written notice, which is submitted in conjunction with this release and attached here to, setting forth any specific issue, condition or ailment in addition to what is specified above, that my child has or that may impact my child's participation in the Programs. I give my consent to have an athletic trainer and/or licensed medical doctor or dentist provide my son/daughter with medical assistance and/or treatment and agree to be financially responsible for the reasonable cost of any such assistance and/or treatment.

Signature of Parent/Guardian

Date