DELAWARE SOCCER CLUB
MEDICAL RELEASE FORM

(Please Print clearly)

As the parent/legal guardian of _____, I request that in my absence the above named player be admitted to any hospital or other 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 other such licensed technicians or nurses, to perform diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above named player.

Player's Date of Birth: _____ Date of last Tetanus booster: _____

Insurance: _____ Policy Holder: _____ Policy#: _____

Known Allergies: _____

Any other medical issues which the coach or trainers should be aware of: _____

_____

_____

Parent/Guardian Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Emergency Contact Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

PARENT OR GUARDIAN (Please Print): _____

PARENT OR GUARDIAN (Signature): _____

RELATIONSHIP TO PLAYER (Please Print): _____

DSC OFFICE USE ONLY: Date Rec'd: _____ Rec'd by: _____