Wayne Wings Youth Soccer Club
Medical Release Form
(Please Print Clearly)

As a parent / legal guardian of _____, I request that in my absence the above named player 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 other such licensed technicians or nurses, to perform any 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 or treatment. I accept full financial responsibility for any such treatment. I also give permission for any transportation required to a medical facility and assume full financial responsibility for said transportation.

Date of Birth / / Date of last Tetanus Booster / /

Known allergies of this player, including any allergies to medicine _____

Any other medical problems which should be noted _____

Family Physician _____ Phone (_____)_____

Practice _____ Preferred Hospital _____

Name of Parent / Legal Guardian _____

Address _____
Street City / Town State Zip

Phone: Home (_____)_____ Work (_____)_____

Person to notify if parent/legal guardian is unavailable _____

Phone: Home (_____)_____ Work (_____)_____

Insurance Carrier _____ Subscriber _____Policy number_____

Recognizing the possibility of injury associated with soccer and in consideration for the USSF/USYSA and its affiliates accepting the registrant for its soccer programs and activities, I hereby release, discharge and/or otherwise indemnify the USSF/USYSA, its affiliated organizations and sponsors, their employees and personnel, including the owners of the fields and facilities utilized for the Programs/Tournaments against any claim by or on behalf of the registrant as a result of the registrant's participation in the Programs/Tournaments and/or being transported to or from same, which transportation I hereby authorize. My son/daughter has received a physical examination by a physician and has been found physically capable of participating in the Programs/Tournaments.

I have read the above paragraph and fully understand and accept responsibility as they are outlined.

Signature of Parent/Legal Guardian _____ Date _____

JURAT

STATE OF _____

COUNTY OF _____

Sworn to and subscribed before me on the _____ day of _____, 20 _____

Notary Public in and for the State of _____

My commission expires _____ _____
Notary