Synergy Soccer Club, 105 Spring St., Hanover, MA 02339 tel: 781-799-4728
www.SynergySoccer.NET

SYNERGY SOCCER

MEDICAL RELEASE FORM

As the 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 to the above minor. I have not been given any guarantee as to the results of examination or 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: _____/_____/_____
Month Day Year

Date of Tetanus Booster: _____/_____/_____
Month Day Year

Known Allergies of this player, including allergies to medicine:

_____

_____

Any other medical problems that should be noted:

_____

_____

Name of Parent or Guardian:

_____

Address:

_____

_____

Phone:
(home) _____ (work) _____ (cell) _____

_____

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Person to notify if parent/guardian is unavailable:

_____

Address:

_____

_____

Phone:
(home) _____ (work) _____ (cell) _____

Insurance Carrier:

_____

Group/Policy Number:_____

Signature of Parent or Guardian:

_____

Date: _____

_____