ROXBOROUGH UNITED SOCCER CLUB

MEDICAL RELEASE FORM

As the Parent/legal guardian of:

Name of Player:	

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 authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

Date of players birth:		**Date of last Tetanus Booster:**	
Know allergies of this player, including any allergies to medicine:			
Any other medical problems which should be noted:			

Family Physician:		**Phone:**	( )

Family Dentist:		**Phone:**	( )

Parent/Guardian:					
Street Address:					
City:		**State:**		**Zip:**	
Phone # H:	( )	**Work #:**	( )		

Person responsible for charges: (if different from above)					
Street Address:					
City:		**State:**		**Zip:**	
Phone # H:	( )	**Work #:**	( )		

Person to notify if parent/guardian is unavailable:					
Street Address:					
City:		**State:**		**Zip:**	
Phone # H:	( )	**Work #:**	( )		

Insurance Carrier:		**Policy Number:**	
Name of Insured:		**Phone:**	( )

Name of Parent / Guardian: _____

Signature of Parent /Guardian: _____

Date: _____Witness: _____