SILVER LAKE SOCCER CLUB
425-481-2665

P.O. Box 12543
Mill Creek, Washington
98082

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:__________

Allergies: ____

Other Medical Conditions:____

Player's Physician:___________________________________ Phone#: ____-____-_____

Name of Parent/Guardian:____
Street Address:____
City:____________________________ State:_____ Zip Code: _____________________

Phone # H:___-___-____ Work#: ___-___-____

Person responsible for charges (if different from above)_____________________________
Street Address:____
City:____________________________ State:_____ Zip Code: _____________________

Phone # H:___-___-____ Work#: ___-___-____

Person to notify if parent/guardian is unavailable:
Street Address:____
City:____________________________ State:_____ Zip Code: _____________________

Phone # H:___-___-____ Work#: ___-___-____

Medical and/or Hospital Insurance Co_____________________Phone # :___-___-_____
Policy Holder____Policy Number________

Signature of Parent /Guardian:____________________ Date:__________________

Sworn to and subscribed before me on the ________ day of____________Yr_______
Notary Public __________________
My Commission expires__________