



AUTHORIZATION FOR MEDICAL TREATMENT AND RELEASE STATEMENT

My Signature below authorizes my permission as parent/guardian of _____,
(Player's name, please print)

A minor for whom I have legal custody, for the holder of this form to obtain medical or dental care for the above named minor as needed in my absence from a recognized medical facility and/or a licensed physician or dentist.

Player Medical Information

Player's Date of Birth: ____ / ____ / ____

Existing medical problems, if any: _____

Allergies, if any: _____

Physician and phone number: _____

Dentist and phone number: _____

Medicine currently being taken: _____

Insurance company and Id. number: _____

Emergency contact other than Parent/Guardian and phone number:

Name: _____ Cell Phone number: _____

Relationship to Player: _____

Furthermore, recognizing the possibility of physical injury associated with soccer, my signature also serves to release, discharge, and/or otherwise indemnify the West Chester United Soccer Club, its coaches, the EPYSA/USYSA, USCS, affiliated soccer organizations, clubs and teams along with employees, volunteers, coaches, and associated personnel of the above organizations against any claim by or on behalf of the above named player. My child has received a physical examination by a physician and has been found physically capable of participating. This release shall remain in effect in an on going basis from year to year.

Signature of Parent/Guardian: _____ Date: _____

Father's Name: _____ Cell Phone number: _____

Mother's Name: _____ Cell Phone number: _____



Address: PO Box 5, Westtown, PA 19395
Office: 610-399-5277 Fax: 610-399-5260
Web Site: www.wcusc.org