

**NORTH KITSAP SOCCER CLUB
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 of the above minor. I have not been given a guarantee as to the results of examination or treatment.

Date of Players Birth _____/_____/_____
Month Day Year Month Day Year

Known allergies and existing medical conditions of this player, including any allergies to medicine

Any other medical problems which should be noted _____

Family Physician _____ Phone _(____)_____

Parent/Guardian _____

Address _____

City/State/Zip _____

Phone _____ H _____ W _____ Cell _____

Person responsible for charges (if different from above) _____

Address _____

City/State/Zip _____

Phone _____ H _____ W _____ Cell _____

Emergency Contact if parent/guardian is unavailable _____

Phone _____ H _____ W _____ Cell _____

Insurance Carrier _____ Policy Number _____

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian

Date