MEDICAL RELEASE FORM

Loudoun Soccer

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. 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_____/_____/____

Mo Day Yr Mo Day Yr

Known allergies of this player, including any allergies to medicine_____

_____

Any other medical problems that should be noted_____

_____

Family Physician_____ Phone (_____)_____

Name of Parent/Guardian_____

Address of Parent/Guardian_____

City/State/Zip_____

Home Phone (_____)_____ Work Phone (_____)_____

Person Responsible for Charges (if different from above)_____

Address _____

City/State/Zip_____

Home Phone (_____)_____ Work Phone (_____)_____

Person to Notify if Parent/Guardian is unavailable_____

Address _____

City/State/Zip_____

Home Phone (_____)_____ Work Phone (_____)_____

Insurance Carrier_____ Policy Number_____

Signature of Parent/Guardian_____

JURAT

STATE OF _____

COUNTY OF _____

Sworn and subscribed before me on the _____ day of _____, 2008.

_____

Notary Public in and for the State of _____

Commission expires _____