MEDICAL RELEASE FORM

THIS FORM SHOULD BE COMPLETED
AND RETURNED TO the UK Coach or Camp Aide

Minor's Name: Date of Birth:

Last First M.I. Mo. /Day/Year

Parent's Name

Home Address

City State Zip Home Phone

Employer Work Phone

Insurance Carrier Name & Address

Policy No.

Notify In Emergency (if other than parent or guardian) Relationship

Address City State Zip Phone

Family Physician Phone

Allergies Last Tetanus

Medical Problems

AUTHORIZATION FOR TREATMENT OF MINOR

I, the undersigned, parent or legal guardian of _____, a minor, do hereby consent to the nurse or physician selected by the authorized AYSO agent to perform routine tests and treatment for the health of my child. In the event I cannot be reached in an emergency, I hereby give permission for the physician selected to hospitalize, secure proper treatments for, and to order injection, anesthesia, or surgery for my child as named above.

Date Signature of Parent/Guardian