MEDICAL RELEASE FORM

Soaring Capital Soccer Club
P.O. Box 390
Elmira, NY 14902

PLAYER'S NAME:

Father's Name, Address, Phone

Mother's Name, Address, Phone

CONSENT FOR MEDICAL TREATMENT & TRANSPORTATION OF MINOR:

As the parent(s) or guardian(s) of the above named player, I hereby give my consent for emergency treatment or medical care prescribed by a duly licensed doctor of medicine. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent. I do hereby authorize the officers, leaders, coaches, or agents of the New York State West Youth Soccer Association and of affiliated members, to transport as required the above named minor to and from the association sponsored events including, but not limited to, athletic and social events.

IN EVENT OF EMERGENCY:

Emergency Contact Person:

Emergency Contact Phone:

MUST BE READ AND SIGNED BY PARENTS/GUARDIANS:
We, the undersigned parents/guardians of the minor named above, do for ourselves, executors, administrators, heirs, agree to hold harmless and agree to indemnify the USYSA, NYSWYSA, the Soaring Capital Soccer Club, Inc, the SCSC Board of Directors, Member Leagues, Member Clubs, Officers, Coaches, Referees, Manager, Owners of Soccer Fields and Facilities utilized or any Sponsors, for any claims that might be asserted by us or our child as a participant in a Soaring Capital Soccer Club event.

Father's Signature:_____ Date: ____/____/____

Mother's Signature:_____ Date" ____/____/____