Spearfish Youth Soccer Association

Health Information/Medical Release

Player Name _____

Address _____ City _____ State _____ Zip_____

Father's Name _____ Work Place_____

Home Phone_____ Work Phone _____

Mother's Name _____ Work Place_____

Home Phone_____ Work Phone _____

My Insurance Company Is _____

Through _____ Phone _____

Policy Number _____

In case I cannot be reached, I designate the following to represent me:

Coach _____ Phone _____

Ass't Coach _____ Phone _____

Our physician is _____ Phone _____

Address _____ City _____ State _____ Zip_____

Medical History

Height_____ Weight _____ Birthdate _____

The player is allergic to _____

The player is presently taking the following medication _____

_____

The player has had the following surgeries _____

_____

Explain any reaction of the player or his/her relative to anesthesia _____

_____

Please provide any additional information that may be helpful in treating this player

_____

_____

I hereby give my permission for any and all medical attention necessary to be administered to my child named at the first of this document, in the event of an accident, injury, sickness, etc., under the direction of the person(s) listed until such time as I may be contacted. This release is effective for a period of one year from the date given below. I also hereby assume the responsibility for payment of any such treatment.

_____ _____

Signature of Parent/Guardian Date