# Enfield Soccer Club

## Medical Information/Treatment Authorization

**Players Identification**

Name: _____

Address: _____

Town: _____ State: _____ Zip: _____

Date of birth: ____/____/____ Age: _____ Sex:_____ Telephone: _____

Please describe any medical problems, (including allergies to medicine, food, animal, plant or insect toxin), physical restrictions, and medication requirements applicable to the above named player.

_____

_____

_____

_____

**Physician/Insurance Information:**

Personal physician:_____ Telephone: _____

Health/ Accident insurance:_____

Policy #/Group #:_____

**Authorization for Medical Treatment**

If a parent or legal guardian cannot be reached, in emergency please notify:

Name:_____ Relationship:_____

Address: _____

Town: _____ State: _____ Zip: _____

Telephone - Home:_____ Cell/Work:_____

**In the case of my unavailability, I hereby give permission to my child's Enfield Soccer Club team coach or his designee to obtain emergency treatment for my child named above.**

Parent or Legal Guardian Name:_____

Address:_____

Telephone - Home:_____ Cell/Work:_____

Date:_____ Parent/ Legal Guardian signature:_____