



SOUTHERN ALLIANCE FUTBOL
MEDICAL RELEASE FORM (SAF TRYOUTS FALL 2017)

I, _____ (Parent/Guardian's Name), hereby give permission for any and all medical attention to be administered to my child _____ (child's name) in the event of accident, injury, sickness, etc., under the direction of the person (s) listed below, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment. **This release is effective for the period of one year from the date of signature.**

Home Address: _____

City / State / Zip: _____

Cell Phone: _____

Insurance Company: _____

Policy Number: _____

In case I cannot be reached, any of the following persons are designated to act on my behalf:

- * **Trainer/Coach conducting Tryout Session**
- * **SAF Director of Coaching**
- * A league representative where my child is playing.
- * Any tournament representative where my child is participating in a tournament.

Players Physician: _____

Physician Address: _____

Phone: _____

Known Allergies: _____

Signature (Parent/Guardian): _____

Date: _____