NEBRASKA STATE SOCCER ASSOCIATION

www.nebraskasoccer.org

10700 Sapp Brothers Drive - Suite B • Omaha, Nebraska 68138 • Phone (402) 596-1616 • Fax (402) 596-0660

MEDICAL RELEASE FORM

Player's Name: _____

As the parent/legal guardian of, I request that in my absence the above-named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

Date of Player's Birth: ____/____/____ (Month / Day / Year)

Date of last Tetanus Booster: ____/____/____ (Month / Day / Year)

Known allergies of this player, including any allergies to medicine: _____

Any other medical problems which should be noted: _____

Family Physician: _____ Phone: _____

Name of Parent/Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Home Phone: _____

Person responsible for charges (if different from above) _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Home Phone: _____

Person to notify if parent/guardian is unavailable _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Home Phone: _____

Insurance Carrier: _____ Policy Number: _____

Signature of Parent/Guardian: _____

[NOTARIZATION] ** Notarization is not required by US Youth Soccer*

STATE OF: _____

COUNTY OF: _____

Sworn to and subscribed before me on the _____ day of _____, _____

Notary Public in and for the State of:: _____

My Commission expires: _____

Signature: _____