



# Medical Release Form

## Player Information (please print)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Gender: M / F Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Player Cell Phone: \_\_\_\_\_ Player email: \_\_\_\_\_

## Parent Information (please print)

Parent/Guardian Name(s): \_\_\_\_\_

Parent Cell Phone(s): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email(s): \_\_\_\_\_

## Waiver/Consent for Medical Treatment:

I, the parent/guardian of the registrant, a minor, agree that I will abide by the rules of KCYS, its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer and in consideration for KCYS/Kent United accepting the registrant for its soccer programs and activities, I hereby release, discharge and/or otherwise indemnify Kent Youth Soccer Association, its affiliated organizations and sponsors, their employees and associated personnel, including the owners of the fields and facilities utilized for the programs, against any claim by or on behalf of the registrant as a result of the registrant's participation in the programs and/or being transported to or from the same, which transportation I hereby authorize.

As parent or legal guardian of the above player, I hereby consent for Emergency Medical Care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve life, limb or well-being of my dependent.

Allergies or Special Needs: \_\_\_\_\_

Medical Conditions/Illnesses: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Insurance ID #: \_\_\_\_\_

Preferred Hospital or Clinic: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (required): \_\_\_\_\_