Eastern Pennsylvania Youth Soccer

4070 Butler Pike, Suite 100, Plymouth Meeting, PA 19462
Phone (610) 238-9966~Fax (610) 238-9933~EPYSA.org

MEDICAL RELEASE

Player's Name: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

EMERGENCY INFORMATION (Please include Area Code)

Father's Name: _____ Mother's Name: _____

Father's Home Phone: ( ) _____ Mother's Home Phone: ( ) _____

Father's Work Phone: ( ) _____ Mother's Work Phone: ( ) _____

Father's Cell Phone: ( ) _____ Mother's Cell Phone: ( ) _____

Father's E-mail: _____ Mother's E-mail: _____

In an emergency, when parents cannot be reached, please contact:

Name: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Name: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Allergies: _____

Other Medical Conditions: _____

Player's Physician: _____

Work Phone: ( ) _____ 2nd Phone: ( ) _____

Medical and/or Hospital Insurance Company: _____ Phone: ( ) _____

Policy Holder: _____ Policy #: _____ Group #: _____

PLEASE COPY BOTH SIDES OF YOUR MEDICAL INSURANCE CARD

onto 1 page (8.5x11) and attach to this form

PARENT'S APPROVAL AND MEDICAL RELEASE

Recognizing the possibility of physical injury associated with soccer and in consideration for the USSF/USYS/EPYSA Youth Soccer and its affiliates accepting the registrant for its soccer programs and activities ("the Programs"), I hereby release, discharge and/or otherwise indemnify the USSF/USYS/EPYSA, its affiliated organizations and sponsors, their employees and associated personnel, including the owner 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.

My son/daughter has received a physical examination by a physician and has been found physically capable of participating in the Programs. I hereby give my consent to have an athletic trainer and/or doctor of medicine or dentistry provide my son/daughter with medical assistance and/or treatment and agree to be responsible financially for the reasonable cost of each assistance and/or treatment.

_____ _____

Signature of Parent/Guardian **Date**