

REMEMBER: NO SHORTENED NAMES OR MIDDLE INITIALS



### New Jersey Youth Soccer Medical Release Form

Player's Name Catherine Smith Date of Birth 04/15/04 Gender M  F   
Address 10 Summit Avenue Town Summit State NJ Zip Code 07901

#### Contact Information

Father's Name John Smith Home Phone 908-522-1234 Work Phone 908-967-1122  
Mother's Name Jennifer Smith Home Phone 908-522-1234 Work Phone 908-967-1133

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

Name Mary Field Home Phone 908-522-7777 Work Phone 973-543-1111

#### Medical Information

Allergies COMPLETE AS APPROPRIATE

Other medical conditions \_\_\_\_\_

Player's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Primary Medical Insurance Company \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

#### PARENT'S APPROVAL AND MEDICAL RELEASE

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

*J. Smith*  
Signature of Parent or Guardian

05/01/15  
Date