Wallingford Youth Soccer League
Medical Release Form

As the parent / 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 Players 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: _____

Phone: (Cell) _____ (H) _____ (W) _____

Person responsible for charges (if different that above): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Cell) _____ (H) _____ (W) _____

Person to notify if parent / guardian is unavailable: _____

Phone: (Cell) _____ (H) _____ (W) _____

Insurance Carrier: _____ Policy Number: _____

Signature of Parent / Guardiar _____