



1477 Park Street Suite 13c
 Hartford, CT 06106
 Tel 860.986.7675
 Fax 888.891.4474
 www.soccerplusct.com



2011-2012 SOCCERPLUS

CONSENT FOR MEDICAL TREATMENT AND RELEASE FORM

Name: _____ Team: _____
 Address: _____ City, State & Zip _____
 Date of Birth: _____ School: _____ Grade: _____
 Mother: _____ Cell Phone _____ Father: _____ Cell Phone _____
 Physician: _____ Phone: _____ Dentist: _____ Phone: _____
 Emergency Contact (other than parent): _____ Phone: _____ Relationship: _____
 Insurance Company: _____ Policy# _____ Address: _____
 Preferred Hospital: _____ Date of last Tetanus immunization: _____
 Drug or Food Allergies _____ Medication(s) taken, dosage & frequency: _____
 Medical Condition(s) to be aware of: _____

Medical Release:

Recognizing the possibility of physical injury associated with soccer and in consideration for the USYSA accepting the registrant for its soccer programs and activities, I hereby release , discharge, and/or otherwise indemnify the CJSA, its affiliated organization, 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 and from the same, which transportation I hereby authorize.

Medical Treatment:

As a parent or legal guardian of the registrant, I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. Medical treatment maybe administered under whatever conditions are necessary to preserve the life, limb, or well being of my dependant.

Parent/Guardian Signature _____ Date _____

Subscribed and sworn to before me this ___ day of _____

 Notary Public