

**ESSEX UNITED SOCCER CLUB
Medical Information and Release Form**

Player's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY INFORMATION

Parent/Guardian: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____

Parent/Guardian: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____

Parent/Guardian: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____

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

Name/: _____ Home Phone: _____ Work Phone: _____

Relationship _____ Cell Phone: _____

Name/: _____ Home Phone: _____ Work Phone: _____

Relationship _____ Cell Phone: _____

Allergies (Reaction/Treatment): _____

Other medical conditions : _____

(For medical conditions, please describe emergency treatment if applicable, e.g., allergic reaction/epipen, asthma/inhaler) _____

Player's Physician: _____ Work Phone: _____

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

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

Parent's Approval and Medical Release

Recognizing the possibility of physical injury associated with soccer and in consideration for the USSF/USYS 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, EUSC, and 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. As the parent or guardian of the above named player, I hereby give my consent to have a duly licensed 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. This care may be given under whatever conditions are necessary to preserve the life, limb, or well being of my dependent.

Signature of Parent/Guardian

Date