

**NORTH KITSAP SOCCER CLUB  
MEDICAL RELEASE FORM**

As the parent/legal 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.

Date of Players Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year Month Day Year

Known allergies and existing medical conditions of this player, including any allergies to medicine

\_\_\_\_\_

Any other medical problems which should be noted \_\_\_\_\_

\_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_(\_\_\_\_)\_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ H \_\_\_\_\_ W \_\_\_\_\_ Cell \_\_\_\_\_

Person responsible for charges (if different from above) \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ H \_\_\_\_\_ W \_\_\_\_\_ Cell \_\_\_\_\_

Emergency Contact if parent/guardian is unavailable \_\_\_\_\_

Phone \_\_\_\_\_ H \_\_\_\_\_ W \_\_\_\_\_ Cell \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_

Printed Name of Parent/Guardian \_\_\_\_\_

Signature of Parent/Guardian

\_\_\_\_\_

Date