

# NEBRASKA STATE SOCCER ASSOCIATION

www.nebraskasoccer.org

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## MEDICAL RELEASE FORM

Player's Name:

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. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

Date of Player's 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:

Work Phone:

Home Phone:

Person responsible for charges (if different from above)

Address:

City:

State:

Zip:

Work Phone:

Home Phone:

Person to notify if parent/guardian is unavailable

Address:

City:

State:

Zip:

Work Phone:

Home Phone:

Insurance Carrier:

Policy Number:

Signature of Parent/Guardian: \_\_\_\_\_

**[NOTARIZATION]** \* Notarization is not required by US Youth Soccer

STATE OF: \_\_\_\_\_

COUNTY OF: \_\_\_\_\_

Sworn to and subscribed before me on the \_\_\_\_\_ day of \_\_\_\_\_,

Notary Public in and for the State of: \_\_\_\_\_

My Commission expires: \_\_\_\_\_

Signature: \_\_\_\_\_

