MEDICAL RELEASE FORM

Please have MEDICAL RELEASE notarized and <u>return it to your team coordinator</u>

As the parent/legal guardian of the player named below, I request that in my absence this 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.

Player's Name _____ Team: _____
(i.e. U-14 Premier, Classic, Legend, United)

Date of Players Birth ___/___/___ Date of last Tetanus Booster ___/___/___
Mo Day Yr Mo Day Yr

Name of Parent/Guardian _____

Address _____

City/State/Zip _____

Phone (Home) _____ (Work) _____ (FAX) _____

Known allergies of this player, including any allergies to medicine _____

Any other medical problems which should be noted _____

Family Physician _____ Phone _____

Person responsible for charges (if different from above) _____

Address _____

City/State/Zip _____

Phone (Home) _____ (Work) _____ (FAX) _____

Person to notify if parent/guardian is unavailable _____

Phone (Home) _____ (Work) _____ (FAX) _____

Insurance Carrier _____ Policy Number _____

Signature of Parent/Guardian _____ Date _____

<u>WAIVER</u>

I recognize and understand that soccer is a sport involving risks not encountered in everyday play. With this understanding, in consideration of Lexington Youth Soccer Association's (LYSA) permitting my child to participate in the youth soccer program, I covenant and agree to indemnify and hold harmless and do release, requite and forever discharge, LYSA, Kentucky Youth Soccer Association (KYSA), the United States Youth Soccer (USYS) and the Lexington Fayette Urban County Government (LFUCG), their officers, Boards of Directors, employees, coaches, referees and other such volunteers as are connected with LYSA, KYSA and USYS in any capacity, for any and all damages, claims, and/or liability arising out of any and all injury to or caused by my child. With the knowledge and understanding of the foregoing, this is to certify that my child has my permission to play soccer in the LYSA program. Further, I hereby authorize any and all emergency medical treatment deemed necessary by any physician, nurse or paramedic. A copy of this authorization shall be as effective as the original.

_____ _____
Signature of Parent / Guardian Date

<u>NOTARY PUBLIC</u>

STATE OF _____

COUNTY OF _____

Sworn to and subscribed before me on the _____ day of _____, _____.

_____

Notary Public in and for the State of _____

Commission expires _____

(Seal Required)