



Capital Soccer Club
Liam and Solon Bailey Memorial Jamboree
Medical Release Form



Players Name: _____ U.S. Citizen Yes ___ No ___

Address: _____

Birth Date: _____ Sex: M ___ F ___

Parent's Phone Home: _____ Work: _____

Email Address: _____

Emergency phone number other than Parent/Guardian

Name: _____ Phone: _____

Primary Medical Insurance Company: _____

Policy Number: _____

Known allergies or other pertinent medical information:

The undersigned recognizes that the game of soccer is a physical activity during which injuries may occur. I certify that my child is in good physical health, and has my permission to participate in Capital Soccer programs. I hereby release and indemnify Capital Soccer Club and its affiliated organizations, sponsors, directors, employees, and volunteers from any liability claim on behalf of the registrant.

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.

Parent/Guardian Signature: _____

Date: _____