

New Jersey Youth Soccer Medical Release Form

Player's Name	Date of Birth	Gender <u>M</u> <u>F</u>
Address	Town	State Zip Code
Contact Information		
Father's Name		
Mother's Name	Home Phone	Work Phone
In an emergency when parents cannot be reac	hed, please contact:	
Name	Home Phone	Work Phone
Medical Information		
Allergies		
Other medical conditions		
Player's Physician	Phone	
Primary Medical Insurance Company		
Policy Holder	Policy #	Group #
PARE	NT'S APPROVAL AND MEDICAL I	RELEASE
registrant for its soccer programs and activity. Jersey Youth Soccer, its affiliated organization and facilities utilized for the Programs against the Programs and/or being transported to or from My son/daughter has received a physical example.	ies (the "Programs"), I hereby release, ns and sponsors, their employees and as t any claim by or on behalf of the regist om the same, which transportation I her amination by a physician and has been	ation for New Jersey Youth Soccer accepting the discharge and/or otherwise indemnify the New sociated personnel, including the owner of fields rant as a result of the registrant's participation in eby authorize. found physically capable of participating in the licine or dentistry provide my son/daughter with
medical assistance and/or treatment and agree	to be responsible financially for the cos	t of each assistance and/or treatment.
Signature of Parent or Guardian	Date	_
Subscribed and sworn to me this	day of, 20	
SignatureNotary Public	My commission expires:	