



# Eastern Pennsylvania Youth Soccer

4070 Butler Pike, Suite 100, Plymouth Meeting, PA 19462

Phone (610) 238-9966~Fax (610) 238-9933~EPYSA.org

## MEDICAL RELEASE

Player's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### EMERGENCY INFORMATION (Please include Area Code)

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Father's Home Phone: ( ) \_\_\_\_\_ Mother's Home Phone: ( ) \_\_\_\_\_

Father's Work Phone: ( ) \_\_\_\_\_ Mother's Work Phone: ( ) \_\_\_\_\_

Father's Cell Phone: ( ) \_\_\_\_\_ Mother's Cell Phone: ( ) \_\_\_\_\_

Father's E-mail: \_\_\_\_\_ Mother's E-mail: \_\_\_\_\_

### In an emergency, when parents cannot be reached, please contact:

Name: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Name: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Allergies: \_\_\_\_\_

Other Medical Conditions: \_\_\_\_\_

Player's Physician: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ 2nd Phone: ( ) \_\_\_\_\_

Medical and/or Hospital Insurance Company: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**PLEASE COPY BOTH SIDES OF YOUR MEDICAL INSURANCE CARD**

**onto 1 page (8.5x11) and attach to this form**

### PARENT'S APPROVAL AND MEDICAL RELEASE

Recognizing the possibility of physical injury associated with soccer and in consideration for the USSF/USYS/EPYSA Youth Soccer and its affiliates accepting the registrant for its soccer programs and activities ("the Programs"), I hereby release, discharge and/or otherwise indemnify the USSF/USYS/EPYSA, its affiliated organizations and sponsors, their employees and associated personnel, including the owner of the fields and facilities utilized for the Programs against any claim by or on behalf of the registrant as a result of the registrant's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize.

My son/daughter has received a physical examination by a physician and has been found physically capable of participating in the Programs. I hereby give my consent to have an athletic trainer and/or doctor of medicine or dentistry provide my son/daughter with medical assistance and/or treatment and agree to be responsible financially for the reasonable cost of each assistance and/or treatment.

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

\_\_\_\_\_  
Date