Virginia Legacy Soccer Club

109 Bulifants Blvd – Suite A
Williamsburg, VA 23188
757-253-8572
www.valegacysoccer.com

PLAYER MEDICAL RELEASE

As the parent/legal guardian of (insert childs name)_____, 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 any x-ray treatment of the above-named 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.

Any known allergies or medical problems of this player, including allergies to medicines:
_____

Family Physician: _____ Phone:_____
Insurance Carrier:_____Policy #: _____

Player's Information:
Address:_____
Street City State Zip

Home Phone: _____

Email: _____

Name of Parent/Guardian:_____

Phone:_____
Home Work Cell
Emergency Contact #1 (If parents are not available): _____
Emergeny Contact #2 (If parents are not available): _____

Signature of Parent/Guardian: _____
Date: _____

Subscribed and Sworn By Me This_____Day of _____
Notary Public_____