Delaware Football Club

email: defc@delawarefc.org | website: www.delawarefc.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/DYSA 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/DYSA, 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**