Washington Youth Soccer
500 S. 336th Street, Suite #100 · Federal Way, Washington 98003-6389
PHONE (253) 4-SOCCER · FAX (253) 925-1830 · TOLL FREE 1-877-424-4318
www.wsysa.com

MEDICAL RELEASE FORM

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.

Date of Players Birth _____/_____/_____ Date of last Tetanus Booster _____/_____/_____
Month Day Year Month Day Ye

Known allergies of this player, including any allergies to medicine _____

Any other medical problems which should be note_____

Family Physician _____ Phone ( )_____-_____

Name of Parent/Guardian _____

Address _____

City/State/Zip _____

Phone Home _____Cell _____Work_____

Person responsible for charges (if different from above) _____

Address _____

City/State/Zip_____

Phone Home _____Cell _____Work_____

Person to notify if parent/guardian is unavailable _____

Phone Home _____Cell _____Work_____

Insurance Carrier _____ Policy Number _____

Signature of Parent/Guardian _____