



VESTAL YOUTH SOCCER ASSOCIATION

P.O. Box 172
Vestal, New York 13850-0172

<http://www.vestalsoccer.com>

Medical Release Form

Player's Name: _____

Should the above named participant become ill or sustain an injury, and a parent or guardian cannot be contacted, permission is granted to call a licensed physician for treatment or to transport the above named participant to a hospital emergency room for treatment.

Signature (Parent or Legal Guardian)

Our Physician is:

Address: _____

Name: _____

City: _____

Address: _____

State: _____ Zip: _____

City: _____

Home Phone: _____

State: _____ Zip: _____

Work Phone: _____

Phone: _____

Hospitalization Insurance: NO/YES (CIRCLE ONE)

Name of insurer: _____

Contract/Policy #: _____

Does youth have any unusual or physical reaction which would require immediate attention?

Allergy: _____

Tetanus Immunization

Drug Reaction: _____

Date: _____

Other: _____

Special instructions/ medical information: _____

Subscribed and sworn to before me this date

Notary Public