West Michigan Youth Soccer Association

MEDICAL RELEASE FORM

Please print all information except signature

I,_____ hereby give my permission for any and all medical

attention necessary to be administered to my child (name)_____
in the event of accident, injury or illness, under the direction of the person(s) listed below, until such time as I may be contacted. This release is effective for a period of one year from the date given below. I also assume the responsibility for the payment of such treatment.

My address is: _____

Home Phone: ( ) _____ Office: ( ) _____

My insurance company is: _____

My policy number is: _____

In case I cannot be reached, any of the following is designated to act in my behalf.

1. Coach: _____

2. Asst. Coach: _____

3. Any league representative where my child is playing.

4. Any tournament representative where my child is playing.

Our physician is _____

Address: _____

Telephone: _____

Known Allergies: _____

_____

Signature (Parent/Guardian) _____

Subscribed and sworn to before me this _____day of _____, 20_____

_____ _____
expiration date