# LAKE WASHINGTON YOUTH SOCCER ASSOCIATION

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# MEDICAL RELEASE FORM

**Parents: Complete this form and return it to your player's Coach or Team Manager.**
**Coaches/Managers: Keep forms with players at all LWYSA/WSYSA activities.** In the event of injury requiring emergency medical attention, this form should accompany the player to the medical facility.

## PERSONAL INFORMATION – PLEASE PRINT NEATLY

| | | | | | | |
|---|---|---|---|---|---|---|
| Player | Last First | Birth Date | ___-___-___ | Male | Female | |
| Mother | Last First | Phone | Day | Evening | | |
| Father | Last First | Phone | Day | Evening | | |
| Address | | City | | State | Zip | |
| Alternate Contact | Last First | Relationship | | Phone | | |
| Address | | City | | State | Zip | |
| **Physician** | Last First | Phone | Day | Emergency | | |
| Local Hospital or Medical Facility Preference | | | | | | |
| Insurance Carrier: | | ID# | | | | |
| Person responsible for charges (if different from above): | | | | | | |

## MEDICAL HISTORY

Note: LWYSA may require a physician's release for participation

| | | | |
|---|---|---|---|
| Allergies | | Prescription Meds | |
| Drug Allergies | | Last Tetanus Booster | Date ____ - ____ - ____ |

Does player have any condition that could potentially limit his/her physical ability or increase risk of injury as a result of participating in athletic activities? Yes___ No___ If Yes, please explain:

## PARENT'S CONSENT

As the parent or legal guardian of the above registered participant, 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 any 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.

I certify that the information provided above is true and accurate to the best of my knowledge.

Signature:__________________________________________ Date:__________________________
Parent or Legal Guardian

## NOTARY REQUIREMENT FOR LWYSA CROSSFIRE PREMIER TEAMS ONLY!

- Signature of Parent/Guardian Must Be Notarized:

State of ______________________ County of ________________

Sworn to and subscribed before me on the ____ day of _______________

Notary Public in and for the State of __________________________

**Signature:**______________________________________________

**Commission expires:** ________________________

*SEAL*

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