I, _____ request that if I am injured and need to be admitted to any hospital or medical facility for diagnosis and treatment, I 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. This care may be given under whatever conditions are necessary to preserve the life, limb, or wellbeing of my dependent. 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 player's birth: _____/_____/_____ Date of last tetanus booster: _____/_____/_____
MONTH DAY YEAR MONTH DAY YEAR

Known allergies of this player, including any allergies to medication:_____

Are there any other medical problems that should be noted:_____
_____

Family Physician:_____ Telephone: _____

Name of parent/legal guardian: _____

Address: _____ City: _____ State: _____ Zip:

Telephone: (___) _____ (___) _____ (___) _____
HOME WORK CELL

Person responsible for charges (if different from above): _____

Address: _____ City: _____ State:_____ Zip:

Telephone: (___) _____ (___) _____ (___) _____
HOME WORK CELL

Person to notify if parent/guardian is unavailable: _____

Telephone: (___) _____ (___) _____ (___)
HOME WORK CELL

Insurance Carrier: Policy number:

IMPORTANT: A notarized medical release is required for out of state travel per ASA Travel Policy.

I HEREBY AUTHORIZE THE OFFICE, LEADER, OR COACH, AGENT(S) OF THE ARIZONA STATE SOCCER ASSOCIATION TO TRANSPORT AS REQUIRED THE ABOVE MINOR TO AND FROM THE ASSOCIATION SPONSORED ACTIVITIES INCLUDING, BUT NOT LIMITED TO ATHLETIC AND SOCIAL EVENTS.

Parent/legal guardian signature:_____ Date: _____