

# KICK IT SOCCER CAMP MEDICAL RELEASE FORM

I, \_\_\_\_\_ (Parent/Guardian's Name) hereby give permission for any and all medical attention to be administered to my child. In the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. 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 also assume the responsibility for the payment of any such treatment. This release is effective for the period of two years from the date given below.

Child Full Name \_\_\_\_\_ Soc. Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Street Address: \_\_\_\_\_

Town: \_\_\_\_\_ St.: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth Date (xx/xx/xx) : \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ Group # \_\_\_\_\_

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

\* Coaches/Staff: Kick It Soccer Camp Coaches/Staff

\* Other (optional) Name: \_\_\_\_\_

## Emergency Contacts

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## Doctor Data

Physician name: \_\_\_\_\_ Dr. Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Street: \_\_\_\_\_

Town: \_\_\_\_\_ St.: \_\_\_\_\_ Zip: \_\_\_\_\_

Known Medical Conditions or Allergies: \_\_\_\_\_

SIGNATURE (PARENT/GUARDIAN) \_\_\_\_\_ DATE \_\_\_\_\_