

# ETSF LIABILITY / MEDICAL RELEASE FORM

Playing Season



Player Name: \_\_\_\_\_  
Last First M.I.

Address: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Sex: M F  
(with area code)

## Contact Information

E-mail Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
(Print)

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
(Print)

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
(if Parent / Guardian is unavailable) (Print)

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

## Medical Information

Date of Last Tetanus Booster: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Known allergies of this player, including any allergies to medicine: \_\_\_\_\_

List any medical problem or prohibition player has: \_\_\_\_\_  
(use back of this form if additional space required)

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Recognizing the possibility of physical injury associated with soccer and in consideration for ETSF accepting registrant for its soccer programs and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify ETSF, its soccer affiliated organizations and sponsors, their employees and associated personnel, including the owners of fields and facilities utilized by the Program, against and claim by or on behalf of Registrant as a result of registrant's participation in its program and/or being transported to or from the same, which transportation I hereby authorize. I further agree to indemnify ETSF and its associated personnel for the cost of repairing and/or replacing any personal property for which ETSF or its associated personnel are liable which results from the negligence or willful acts of Registrant.

As the parent/legal guardian of \_\_\_\_\_, 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 also assume the financial responsibility for any medical treatment for my child.

STATE OF \_\_\_\_\_  
COUNTY OF \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent / Legal Guardian

\_\_\_\_\_  
Signature Notary Public

Sworn to and subscribed before me on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  
Notary Public in and for the State of \_\_\_\_\_  
My Commission Expires \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year