

**BLUE RIDGE YOUTH SOCCER ASSOCIATION
MEDICAL RELEASE FORM**

In case of emergency, we hereby give permission to the medical staff closet available licensed medical facility or physician; secure proper treatment for, and to order injection, anesthesia, or surgery for our child, _____ . We hereby accept full financial responsibility for such treatment.

Parent Name _____ Phone _____

Address _____

Insurance Carrier _____ Policy # _____

If we cannot be reached in an emergency, please notify:

Name _____ Phone _____

Address _____ Phone _____

Doctor's Name _____ Phone _____

Allergies _____

Any medical condition the coach should be aware of? _____

Date _____ Parent/Guardian Signature _____

**THIS FORM MUST BE COMPLETED AND TURNED INTO THE COACH BEFORE
YOU CHILD WILL BE ALLOWED TO PLAY SOCCER. THANK YOU**
