
South County Youth Soccer Club
148 High St. Unit #1
Wakefield, RI 02879 Phone: 401-782-8200 Email: scysc1@gmail.com

MEDICAL RELEASE WAIVER

PLAYER'S NAME: _____

PLAYER'S ADDRESS: _____

DATE OF BIRTH: _____

HOME/CELL PHONE: _____

PARENT #1 _____ Phone: _____

PARENT #2 _____ Phone: _____

Medical Conditions: _____

Known Allergies: _____

Medical Insurance: _____

Policy Holder: _____

Policy Number: _____ Group #: _____

Player's Doctor: _____ Phone: _____

In an emergency, when parents cannot be reached please contact:

Name: _____ Phone: _____

Recognizing the possibility of physical injury associated with soccer and in consideration for the USSF/USYSA and its affiliates accepting the registrant for its soccer programs and activities, I hereby release, discharge and/or otherwise indemnify the USSF/USYSA, its affiliated organizations and sponsors, their employees and associated personnel, including the owner of fields and facilities utilized for the Programs against any claim by or on behalf of the registrant as a result of the registrant's participation in the programs and/or being transported to or from the same, which transportation I hereby authorize.

I hereby give my consent to have an athletic trainer and/or doctor of medicine or dentistry provide my son/daughter with medical assistance and/or treatment and agree to be responsible financially for the reasonable cost of each assistance and/or treatment.

Name_____ Date_____