ARLINGTON TRAVEL SOCCER CLUB
CONSENT AND MEDICAL AUTHORIZATION FORM

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, pain relief measures and x-ray treatment of the above minor. 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. I request and authorize the hospital or medical facility and its staff to share information on the medical condition of my child with the parent, coach or assistant coach associated with her soccer team that represents him/herself as the responsible adult in my absence.

Player's Birth Date _____/_____/_____ (mm/dd/yyyy) Date of last tetanus booster _____/_____/_____

Known Medical Problems/Allergies: _____

_____

Parents/Guardian _____

Home Address _____

Home Phone _____ Work (Mother) _____ Work (Father) _____

Cell (Mother) _____ Cell (Father) _____ Fax _____

Family Physician _____ Phone _____

Physician Address _____

Person responsible for charges (if different from above) _____

Person's Address _____

Person's Home _____ Work _____ Cell _____

Insurance Company _____ Policy Number _____

Address for Submitting Claims _____

_____ _____

Signature of Parent/Guardian Date Signed