## 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 med			
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 responsi	ible adult in my absence.
		Player's Birth Date/ (mm/dd/yyyy	Date of last tetanus booster//
		Known Medical Problems/Allergies:	
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		