

# CSSC Emergency Medical Release/Information Form

Player's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Parents/Guardian Name(s): \_\_\_\_\_  
Father Mother

Father's Work Phone: \_\_\_\_\_ Work Location/Hours: \_\_\_\_\_

Mother's Work Phone: \_\_\_\_\_ Work Location/Hours: \_\_\_\_\_

Cell Phone Father: \_\_\_\_\_ Cell Phone Mother: \_\_\_\_\_

Alternate Contact if Parent/Guardian unavailable:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Preferred Facility for Medical Treatment: \_\_\_\_\_

Medical Insurance Carrier/HMO: \_\_\_\_\_ Policy #: \_\_\_\_\_

Please list history of any previous injuries or operations: \_\_\_\_\_

Special Medical Conditions (including asthma): \_\_\_\_\_

Any Special Restrictions or Remarks: \_\_\_\_\_

Allergies (Please give specific instructions for severe or dangerous allergic reactions): \_\_\_\_\_

My child may take the following when judged appropriate by coaching staff for minor illness or injury:

Aspirin \_\_\_\_\_ Tylenol \_\_\_\_\_ Ibuprofen \_\_\_\_\_ None: \_\_\_\_\_

**In case of accident or serious illness, I request the Central Susquehanna Soccer Club (CSSC) to contact me or my designate. If this cannot be done I authorize the CSSC Coaching Staff to call the physician listed above and follow his/her instructions. If the physician named above cannot be reached CSSC may seek medical services deemed necessary including emergency care. I realize CSSC cannot assume responsibility for the payment of medical expenses.**

\_\_\_\_\_  
**Parent or Guardian's Signature**

\_\_\_\_\_  
**Date**