TOPSoccer Medical Authorization/Release

Spring 2003 Burke Athletic Club

Important Note: The following information is required in the event that medical treatment or hospital Emergency Room Treatment is needed for the player named below. The information contained herein will be kept in the strictest confidence and will be used only to facilitate medical treatment in the event the player named below is injured. Failure to complete the following information will mean the player named below will NOT be eligible to participate in BAC TOPSoccer practices and games.

Player Information

Player's Name: _____

Date Of Birth: ____/____/____ Height: _____ Weight: _____

Parent/Guardian Information

Name: _____

Address: _____

Home Phone: (___)_____Work Phone: (___)_____ Cell Phone: (___)_____

Emergency, contact (other than parent/guardian):

Name:_____ Relationship to Player:_____ Home Phone:_____

Work Phone:_____ Cell Phone:_____

Physician Information

Family Physician:_____ Phone:(___)_____

Address:_____ City, State:_____

Hospital Preference:_____

Medical/Insurance Information

Known allergies and medical conditions:_____

Medicines taking regularly:_____

Hospitalization Insurance Co.:_____ Subscriber:_____

Policy No.:_____

___ Check here if the player is not covered by a medical insurance policy. (NOTE: Medical insurance is NOT REQUIRED.)

PLEASE READ CAREFULLY: I/We understand that in the event of an injury, basic First Aid may be administered on-site by the coach or other volunteer, who is hereby resolved of all liability for treatment. I/We further understand that in the event of an injury requiring emergency treatment, in my absence, I/We hereby authorize transportation of the above minor to a hospital or other facility of my choice for emergency medical treatment as may be necessary for his or her well being.

Parent/Guardian MUST Sign _____ Date ____/____/____

NOTE: Medical Fact Statement must also be filled in completely.