ASG FLORIDA MEDICAL RELEASE FORM

I, _____ (parent/guardian's name) hereby give permission for any and all medical attention to be administered to my child_____ (child's name) in the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

Address: _____
Home Phone: _____
Insurance Co: _____
Policy Number: _____

In case I cannot be reached, any of the following person/s is/are designated to act on my behalf:

Coach: _____
Assistant Coach: _____
Team Manager: _____
Parent: _____

Medical Information

Physician: _____
Address: _____
Phone: _____
Known Allergies: _____

You agree to hold harmless Warner Soccer, its staff, coaches, club parents and any other persons who, under the tenets of the Good Samaritan law, attempt to assist your child during a medical emergency.

Signature (parent/guardian) _____ Date _____