Soccer Academy Club Toluca Atlanta

Medical Release Form

Player's Name: _____

Address (Street, City, Zip) _____

Home Phone: _____

Mother's Name: _____ Cell Phone # _____

Father's Name: _____ Cell Phone # _____

Insurance Company: _____ Policy/Group # _____

Physician's Name: _____

Address: _____

Phone: _____

Known Allergies: _____

Medications (use back, if necessary): _____

Tetanus Shot in last 5 years: ☐ Yes ☐ No Does player wear glasses or Contact lenses? ☐ Yes ☐ No

Emergency Contacts to call if parents are unavailable (please list weekend/evening numbers):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Recognizing the possibility of physical injury associated with soccer and in consideration for S. A. C. T. A. and its affiliates accepting the registrant for its soccer programs and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify the S. A. C. T. A. , its affiliated organizations and sponsors, their employees and associated personnel, including the owners of the fields and facilities utilized for the Programs against any claim by or on behalf of the registrant as a result of the registrant's participating in the Programs and/or being transported to or from the same, which transportation I hereby authorized. My child has received a physical examination by a physician and has been found physically capable of participating in the Programs. ***Therefore, I grant S.A.C.T.A. and its representatives permission to act as my surrogate for my child in the area of obtaining medical treatment by a doctor of medicine or dentistry. I also assume the financial responsibility for any medical treatment for my child.***

Signature of Parent/Guardian: _____ Date: _____

Subscribed and sworn before me, this _____ day of _____, 20_____.

_____

Notary Public