



## RELEASE / MEDICAL AUTHORIZATION FORM *Camp of Champions*

### RELEASE

I, the undersigning, am the parent or legal guardian of the registrant, OR am the registrant, age 18 or older, hereby agrees that the registrant will abide by the rules of Eastern FC (EFC), and its affiliated organization and sponsors. Recognizing that soccer is a rigorous sport and the possibility of physical injury associated with soccer and in consideration for EFC, and accepting the registrant for its soccer programs and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify EFC, and its affiliated organizations and sponsors, their employees and associated personnel, including team coaches, game officials, and 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 participation in "the Program" and/or being transported to or from the same, which transportation I hereby authorize.

### MEDICAL AUTHORIZATION

I, the undersigning, am the parent or legal guardian of the registrant, OR am the registrant, age 18 or older, do hereby give my permission for the registrant to receive any and all medical treatment, assistance, or care administered by a duly licensed physician or hospital in the event of an injury, accident, or sickness while he/she is being transported to, or is attending any game or other event conducted or sponsored by EFC, the CJSA, the US Club, the USYS, or its affiliated organizations, until such time as I may be contacted. I also hereby assume responsibility for the payment of any such treatment.

I confirm that registrant named below is covered by a medical insurance policy – policy name and number - \_\_\_\_\_ provided by my family or otherwise. **This release and medical authorization is effective for one year from the date given below.**

Registrant (child): \_\_\_\_\_ Registrant (child) School: \_\_\_\_\_ Gender \_\_\_\_\_

Phone Number: \_\_\_\_\_ Home Address: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Email address: \_\_\_\_\_

### MEDICAL INFORMATION

Registrant's (child's) Physician: \_\_\_\_\_ Physician's Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ \_\_\_\_\_

Known Allergies or other pertinent information: \_\_\_\_\_

I further state that I have carefully read the foregoing release and medical authorization and know and understand the content thereof, and freely sign the same on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Signature of parent/legal guardian OR registrant (if age 18 or older): \_\_\_\_\_ Print Name: \_\_\_\_\_