



P.O. Box 8867  
New Fairfield, CT 06812

\_\_\_\_\_ Player Name

### Medical Release and Treatment Form

I hereby acknowledge that participation in soccer competition carries with it potential hazard. I, therefore, release the New Fairfield Soccer Club and its team coaches, officers, game officials and the town of New Fairfield from liability in the event of injury while engaged in play or practice under their direction, sponsorship or control.

I also give my permission for any and all medical attention necessary to be administered to my child (NAME) \_\_\_\_\_ in the event of an accident, injury, sickness or other medical issue, under the direction of the person(s) listed below, until such time that I may be contacted. This release is effective for a period of one year from the date given below. I also hereby assume the responsibility for payment for any such treatment.

The following are designated to authorize emergency medical treatment:

Coach: \_\_\_\_\_ Phone: \_\_\_\_\_

Assist Coach: \_\_\_\_\_ Phone: \_\_\_\_\_

Assist Coach: \_\_\_\_\_ Phone: \_\_\_\_\_

Signed (Parent/Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact Phone Number(s): \_\_\_\_\_

Child Doctor/Contact Number: \_\_\_\_\_

Known Allergies or Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_