Estacada Youth Soccer Association

PO BOX 832
Estacada, OR 97023
www.estacadayouthsoccer.com

PLAYER NAME: _____

PARENT/GUARDIAN NAME: _____

ADDRESS: _____

BEST CONTACT NUMBER: _____ 2nd NUMBER: _____

INSURANCE COMPANY: _____ POLICY NUMBER: _____

PHYSICIAN: _____ PHONE: _____

PREFERRED HOSPITAL: _____

EMERGENCY CONTACT & NUMBER: _____

KNOWN ALLERGIES: _____

OTHER HEALTH CONSIDERATIONS: _____

_____

I hereby give permission for any and all medical attention to be administered to my child in the event of accident, injury, sickness, etc. under the direction of authorized Estacada Youth Soccer Association representatives, 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.

In case I cannot be reached, any Estacada Youth Soccer Association representative where my child is playing or participating in a tournament has my permission to seek, administer, and/or authorize care.

SIGNATURE: _____ DATE: _____