



**OLYMPIC DEVELOPMENT PROGRAM  
PLAYER MEDICAL RELEASE FORM**

PLAYER'S NAME \_\_\_\_\_ SEX \_\_\_M \_\_\_F DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

**EMERGENCY INFORMATION**

MOTHER'S NAME \_\_\_\_\_ HM PH (\_\_\_\_) \_\_\_\_\_ WK PH (\_\_\_\_) \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_ HM PH (\_\_\_\_) \_\_\_\_\_ WK PH (\_\_\_\_) \_\_\_\_\_

**IN AN EMERGENCY WHEN PARENTS CANNOT BE REACHED, PLEASE CONTACT:**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_ CELL PHONE (\_\_\_\_) \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_ CELL PHONE (\_\_\_\_) \_\_\_\_\_

ALLERGIES \_\_\_\_\_

OTHER MEDICAL CONDITIONS \_\_\_\_\_

PLAYERS PHYSICIAN \_\_\_\_\_ HM PH (\_\_\_\_) \_\_\_\_\_ WK PH (\_\_\_\_) \_\_\_\_\_

MEDICAL AND/OR HOSPITAL INS. CO. \_\_\_\_\_ PH (\_\_\_\_) \_\_\_\_\_

**(PLEASE COPY BOTH SIDES OF YOUR MEDICAL INSURANCE CARD AND ATTACH TO THIS FORM)**

POLICY HOLDER \_\_\_\_\_ POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

**PARENTS APPROVAL AND MEDICAL RELEASE**

RECOGNIZING THE POSSIBILITY OF PHYSICAL INJURY ASSOCIATED WITH SOCCER AND IN CONSIDERATION FOR THE USSF/USYSA AND ITS AFFILIATES ACCEPTING THE REGISTRANT FOR ITS SOCCER PROGRAMS AND ACTIVITIES (THE "PROGRAMS"), I HEREBY RELEASE, DISCHARGE, AND/OR OTHERWISE INDEMNIFY THE USSF/USYSA, IT'S AFFILIATED ORGANIZATIONS AND SPONSORS, THEIR EMPLOYEES AND ASSOCIATED PERSONNEL, INCLUDING THE OWNERS OF 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 "PROGAMS" AND/OR BEING TRANSPORTED TO OR FROM THE SAME, WHICH TRANSPORTATION I HEREBY AUTHORIZE.

MY SON/DAUGHTER HAS RECEIVED A PHYSICAL EXAMINATION BY A PHYSICIAN AND HAS BEEN FOUND PHYSICALLY CAPABLE OF PARTICIPATING IN THE "PROGRAMS". I HEREBY GIVE CONSENT TO HAVE AN ATHLETIC TRAINER AND /OR DOCTOR OF MEDICINE OR DENTISTRY PROVIDE MY SON/DAUGHTER WITH MEDICAL ASSISTANCE AND/OR TREATMENT AND AGREE TO BE RESPONSIBLE FINANCIALLY FOR THE REASONABLE COST OF SUCH ASSISTANCE AND/OR TREATMENT.

**SIGNATURE OF PARENT/GUARDIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PRINT PARENT/LEGAL GUARDIAN NAME** \_\_\_\_\_