



SF CHRISTIAN HIGH SCHOOL SOCCER
Affiliated With Sioux Falls Soccer
Medical Release

I hereby give my permission for any and all medical attention necessary to be administered to my child, _____ in the event of an accident, injury, sickness, etc. under the direction of the person(s) listed below, until such time as 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 of any such treatment.

Player Name: _____ Date of Birth _____

Parent(s) Name: _____

Address: _____

City: _____ State _____ Zip _____

Phone Numbers: Home () _____ Work () _____ Cell () _____

Insurance Company: _____

Through: _____

Policy Number: _____

In case I can not be reached, either of the following is designated:

Coach: _____ Phone: () _____

Assistant Coach: _____ Phone: () _____

Physician is: _____

Address: _____

Phone: () _____ Hospital _____

Known Allergies: _____

Parent Signature

Date