

**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