Emergency Medical Informational Form

20___ Season

Player's Name: ______________________________ Home phone: ______________

Address _____________________________ City _____________ Zip ______________

Father's Name __________________________ Work Phone ____________________

Mother's Name _________________________ Work Phone ____________________

Emergency
Contact_____________________________Relationship _________Phone_________

Family Physician ___________________________________Phone_________________

Dentist ____Phone_________________

Preferred Hospital/Clinic___________________________Phone_________________

Does your child have any allergies or require special medications? If yes, explain:
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CONSENT FOR EMERGENCY MEDICAL TREATMENT
I/We the parent(s) or guardian(s) of _____________________________ give permission for emergency Medical/Dental treatment for my/our child if I/We cannot be contacted, and release Graham Youth Soccer Association (GYSA) of any liability.

Signature of Parent/Guardian _____________________________

Date_____________________________