



Tompkins County United Soccer Club

P.O. Box 3957

Ithaca, NY 14852-3957

www.tcunitedsoccer.org

League Member of New York State West Soccer Association

Affiliated with the United States Youth Soccer Association, United States Soccer Federation and FIFA

MEDICAL RELEASE FORM

Please Print Clearly and COMPLETE ALL Applicable Items

Name: Last _____ First _____ Initial _____

Address _____

City: _____ **State:** _____ **Zip Code** _____

Birthdate: (mm/dd/yyyy) _____ **Gender:** M F **School** _____ **Grade in School** _____

Parent 1: _____ **Telephone: (H)** _____ **(C)** _____

Parent 2: _____ **Telephone: (H)** _____ **(C)** _____

Physician: _____ **Telephone:** _____

Dentist and/or Orthodontist: _____ **Telephone:** _____

Emergency Contact Name: _____ **Telephone:** _____

List any medical problems we should know about: _____

I, the undersigned legal parent/guardian of the child listed below, hereby give permission for my child to participate in the **Tompkins County United Soccer Club** ("The Club") at my and his or her own risk. On behalf of myself, my child and any other guardian, I agree that we will abide by the rules and regulations of the program and will accept in good faith any and all decisions of the officials/person(s) in charge.

Recognizing the possibility of physical injury associated with soccer and in consideration for The Club accepting the applicant for its soccer programs and activities ("The Programs"), I hereby release, discharge and/or otherwise indemnify its affiliate organizations and sponsors, their employees and association personnel, including the owners of fields and facilities used for The Programs, against any claim by or on behalf of the applicant as a result of the applicant's participation in The Programs and/or being transported to or from the same, which transportation I hereby authorize.

This child has had a physical exam within the last year and there is no medical restriction(s) to prevent program participation. I and the above applicant hereby give consent for emergency care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve life, limb, or well-being of my dependent.

Signature of Parent/Guardian: _____ **Date:** _____

Notary Use:

Notary Public (required for out-of-state play)