GATES YOUTH SOCCER LEAGUE
MEDICAL RELEASE AND LIABILITY WAIVER

Player: _____ Team: _____

Address: _____ Parents: _____

_____ Home Phone: _____

Date of Player's Birth _____/_____/_____ Cell Phone (s): _____
Month Day Year

Emergency Contact: _____ Work Phone(s): _____
(Other than parent)
Emergency Phone: _____ Preferred Hospital: _____

Doctor: _____ Dentist: _____

Doctor Phone: _____ Dentist Phone: _____

Insurance Carrier: _____ Policy Number: _____

Known allergies of this player, including any allergies to medicines: _____

_____

Any other medical conditions / health concerns that should be noted: _____

_____

CONSENT FOR MEDICAL TREATMENT:

As the parent or guardian of the above- named player, I request that in my absence the above- named player be admitted to any hospital or medical facility for diagnosis and treatment. I authorize all license physicians, dentist and staff to perform any diagnostic, treatment, X-ray, and operative procedures for the above-named player. I have not been given a guarantee as to the results of any examination or treatment. I also assume the responsibility for the payment of any such treatment, including, but not limited to transportation for required treatment. This release is effective for a period of one year from the date given below.

RELEASE OF LIABILITY:

Recognizing the possibility of injury associated with soccer and in consideration for the USSF/USYSA/NYSWYSA/RDYSL and their affiliates accepting the above-named player for its soccer program and activities, I hereby release, discharge, and/or otherwise indemnify the USSF/USYSA/NYSWYSA/RDYSL, their affiliated sponsors and organizations, their employees, personnel and volunteers, including the owners of the field and facilities utilized for the League/Tournament contents, against any claim by or behalf of the above-named player as a result in the player's participation.

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