

As the parent/legal guardian of I request that in my absence the above-named player to be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of my dependant. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.  Date of player's birth://			
Are there any other medical problems	s that should be noted:		
Family Physician:		hone:	
Name of parent/legal guardian:			
Address:	City:	State:	Zip:
Telephone: ()	( )	()	CELL
Person responsible for charges (if diff			
Address:	City:	State:	Zip:
Telephone: ()	( )	()	
Person to notify if parent/guardian is			
Telephone: (			
I HEREBY AUTHORIZE THE OFFI SOCCER ASSOCIATION TO TRAN ASSOCIATION SPONSORED ACT EVENTS.	NSPORT AS REQUIRED THE	ABOVE MINOR TO AN	D FROM THE
Parent/legal guardian signature:		Date:	
STATE OF}			
STATE OF } ss COUNTY OF }			(Seal)
On this day of, 20 whose identity was proved to me on this document, and who acknowledge	, before me personally appear he basis of satisfactory evidence	e to be the person whose n	
Notary	Public		
My Cor	mmission expires:		