



# Dakota Alliance Soccer Club

## Medical Release Waiver

Player's Name \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Team Name \_\_\_\_\_ Coach \_\_\_\_\_

Emergency contact other than parent/legal guardian:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_ Hospital \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Please list any medical history which would aid in an emergency, allergies to medications, other:

\_\_\_\_\_  
\_\_\_\_\_

The above listed player has received a physical exam by a physician and is physically fit to participate in soccer activities.

The player has been granted permission to attend and participate in and with teams, leagues, tournaments, camps and other soccer activities sponsored by USYSA. I also agree that the above player will abide by the rules of USYSA, its affiliated organizations and sponsors. In exchange for the privilege of the above player participating in the activities, I, the undersigned, waive any legal claim against those associated with these soccer activities, in the event the player is injured while participating in these soccer activities, and travel to and from the same, which transportation I hereby authorize.

I, the undersigned, give my consent, in case of injury, for an athletic trainer, medical doctor, doctor of dentistry, nurse, hospital or clinic to provide the player with medical assistance and/or treatment to preserve the life, limb, and/or well-being of the above named player. I agree to be financially responsible for the reasonable costs of such assistance and/or treatment.

Note: The undersigned signature must be signed in the presence of a Notary Public. (This service is available at the DASC office).

Signature of Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Address of Parent/Legal Guardian \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Dad's Cell # \_\_\_\_\_ Mom's Cell # \_\_\_\_\_

SUBSCRIBED AND SWORN THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 20 \_\_\_\_\_

SEAL

NOTARY PUBLIC \_\_\_\_\_  
STATE OF SOUTH DAKOTA

MY COMMISSION EXPIRES \_\_\_\_\_