

I, request tha	t if I am injured and need to be	admitted to any hosp	ital or medical
facility for diagnosis and treatment, I authorize Doctors of Dentistry or other such licensed tec procedures, operative procedures and x-ray tre	hnicians or nurses, to perform a	ny diagnostic proced	lures, treatment
necessary to preserve my life, limb, or well-be or treatment. I authorize the hospital or medica above-named player.			
Date of player's birth:////	Date of last tetanus booster:	NTH DAY YEAR	
Known allergies of this player, including any a			
Are there any other medical problems that show	ıld be noted:		
Family Physician:	mily Physician: Telephone:		
Name of parent/legal guardian:			
Address:	City:	_ State:	Zip:
Telephone: ( )	( ) WORK	()	CELL
Person responsible for charges (if different from	m above):		
Address:	City:	State:	Zip:
Telephone: ()	( )	()	CELL
Person to notify if parent/guardian is unavailab			
Telephone: ()	( )	()	CELL
Insurance Carrier:	Policy number:		
I HEREBY AUTHORIZE THE OFFICE, LEASOCCER ASSOCIATION TO TRANSPORT FROM THE ASSOCIATION SPONSORED AND SOCIAL EVENTS.	AS REQUIRED, ME, THE AB	OVE NAMED PLA	YER, TO AND

Date: \_\_\_\_\_

Player signature: