



2016-2017 Medical Release

Athlete Name _____ Address _____

City, State, Zip _____ Birthdate _____

Email _____ Cell Phone _____

Parent _____ Parent _____

Cell Phone _____ Cell phone _____

Home Phone _____ Home Phone _____

Work Phone _____ Work Phone _____

Email _____ Email _____

Insurance Coverage Name/Birthdate of Policy Holder

Company _____ ID# _____

Policy # _____ Expiration Date _____

Name of Policy Holder _____

Medical History

Allergies _____

Medication _____

Impact Baseline Test Date and Location _____

Current Injuries or Other Medical Information _____

Athlete Medical Release: Athlete or Parent, if athlete is under the age of 18 years, hereby authorizes USSA/Northern Division/Western Region Staff to secure hospital, medical, surgical and dental care or treatment and/or procedures for the above named athlete. Parent also consents that in the event of injury to the athlete, coaches can authorize that athlete to receive care, treatment and /or procedures, under the instructions and directions of the licensed physicians on call at the emergency room of the nearest hospital or emergency facility. USSA/Northern Division/Western Region shall notify Parent at the earliest possible time before, during, or after such care, treatment and/or procedures are authorized. Parent knowingly and voluntarily consents in advance to such care, treatment and or procedures to encourage physicians and USSA/Northern Division/Western Region to exercise their best judgment as to the requirements of such care, treatment and/or procedures. Parent specifically holds harmless and indemnifies USSA/Northern Division/Western Region of and from any and/or claims of any nature arising out of the provision of such care, treatment and/or procedure.

Athlete Signature _____ Date _____

Parent or Guardian Signature _____ Date _____