



# Osceola Youth Soccer Association Medical Release

I, \_\_\_\_\_ (Parent/Guardian's Name)  
hereby give permission for any and all medical attention to be administered to my child  
\_\_\_\_\_ (Child's Name). In the event of accident, injury, sickness, etc.,  
under the direction of the person(s) listed below, until such time as I may be contacted. I also  
assume the responsibility for the payment of any such treatment. This release is effective for the  
period of one year from the date given below.

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

In case I cannot be reached, any of the following persons is designated to act on my behalf.

- Coach: \_\_\_\_\_
- Assistant Coach: \_\_\_\_\_
- A league representative where my child is playing
- Any tournament representative where my child is participating in a tournament

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Known Allergies: \_\_\_\_\_

Signature (Parent/Guardian) \_\_\_\_\_ Date \_\_\_\_\_

Subscribed and sworn before me,

this \_\_\_\_\_ day of \_\_\_\_\_, 201\_\_

\_\_\_\_\_  
Notary Public