



VIRGINIA FUTSAL MEDICAL RELEASE FORM

As the parent/legal guardian of _____, born _____, I hereby give my consent and permission for the player named above to be medically and/or surgically treated for injuries and/or illness of any kind or seriousness under the direction of Team Officials with valid US Futsal Member Pass, until such time as I can be contacted. Further, I give my consent and permission to the physician and/or hospital and/or other health care provider selected to provide medical or surgical treatment, including, without limitation, dental care, hospitalization, injection, anesthesia, invasive surgery or any other form or kind of medical or surgical care (emergency or otherwise) for the player.

Known allergies of this player, including any allergies to medicine:

Family Physician: _____ Phone: _____

Medical Insurance Policy Name: _____ Policy #: _____

Name of Parent/Guardian: _____

Address: _____

City/State/Zip Code: _____

Phone: (H) _____ (C) _____

Name of Parent/Guardian: _____

Address: _____

City/State/Zip Code: _____

Phone: (H) _____ (C) _____

Person to notify if parent/guardian is unavailable: _____

Phone: (H) _____ (C) _____

Signature of Parent/Guardian: _____

Date: _____