

PO Box 212
Parsippany, New Jersey
07054



Medical Release Form

Please Return To Team Coach At First Practice

This Form To Be Carried By Team Manager At ALL Soccer Functions

Parents or Guardian's Authorization

In case of emergency, if family physician cannot be reached, I hereby authorize _____
(player's name)

born _____ To be treated by another qualified, licensed physician who is available.
(date of birth)

FAMILY PHYSICIAN _____ PHONE _____

STREET *CITY* *ST* *ZIP*

Please indicate any and all physical limitations: _____

Does your child have a neurological or perceptual problem? Y: N

Date of latest Tetanus Toxoid Booster: _____
(Month/YYYY)

Choice of Hospital, if needed: _____

SIGNED: _____

Phone Number of Parent or Guardian _____ Cell: _____

Emergency contact if parent/guardian not available:

1. NAME: _____ PHONE: _____

2. NAME: _____ PHONE: _____