Coral Springs Youth Soccer Player Medical Form

|__|__|__|__|__|__|__|__|__|__|__|__| |__|__|__|__|__|__|__|__|__|__|
Players Last Name First Name

Male ___ Female ___ Birthdate |__|__|__|__|__|__|
Month Day Year

|__|__|__|__|__|__|__| |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
House # Street Name

|__|__|__|__|__|__|__|__|__|__|__|__|__|__| |__|__| |__|__|__|__|__|
City State ZIP Code

Primary Phone: |__|__|__| |__|__|__| |__|__|__|__|
(Area Code)

Secondary Phone: |__|__|__| |__|__|__| |__|__|__|__|
(Area Code)

School Attending: _____
List Any Medical Problem or Prohibitation Player Has: _____
_____
School: _____ Clinic: _____ Camp: _____

Parent/Guardian (please print): _____
Person to Notify in Emergency: _____ Phone: _____
Alternate Emergency Contact: _____Alt. Phone: _____
Doctor to Notify in Emergency: _____ Phone: _____
Hospital Preference, If Any _____ City: _____

THE UNDERSIGNED, PARENT/GUARDIAN OF MINOR _____DO HEREBY AUTHORIZE THE OFFICER, LEADER, OR COACH, AGENTS OF CORAL SPRINGS YOUTH SOCCER, INC., TO TRANSPORT, AS REQUIRED, THE ABOVE MINOR TO AND FROM CORAL SPRINGS YOUTH SOCCER SPONSORED ACTIVITIES INCLUDING, BUT NOT LIMITED TO, ATHLETIC EVENTS.

Signature of Parent/Guardian _____
_____

CONSENT FOR MEDICAL TREATMENT (MINOR)

I, HEREBY, GIVE MY CONSENT FOR ALL MEDICAL CARE PRESCRIBED BY A DULY LICENSED DOCTOR OF MEDICINE FOR _____ AS HIS/HER PARENT OR LEGAL GUARDIAN. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB, OR WELL-BEING OF MY DEPENDENT.

Date: _____ **Signed:**_____
Address: _____**Phone:**_____
City: _____**Zip:** _____