LEGACY UNITED SOCCER CLUB
MEDICAL RELEASE FORM

Player Information: (Please print)

Player Name: First: _____ Last: _____

Birth Date: _____/_____/_____ Age: _____ Gender: M F

Address:_____

City: _____ State: _____ Zip: _____

Father's Name: _____ Cell Phone: _____

Mother's Name: _____ Cell Phone: _____

Emergency Contact: _____ Cell Phone: _____

Primary Email: _____

Medical Release

Medical Conditions: _____

Medical Release: I, _____, the parent/guardian of _____ hereby give my permission for Legacy United SC Staff to procure necessary medical treatment, until such time as I may be contacted, for my child/ward should they be injured or require medical attention while playing or practicing as members of Legacy United SC. This permission shall be in effect for one year from date of signing.

Parent Guardian Signature: _____ Date: _____