

Medical Release Form
Achab Soccer Academy

Player Information

First Name: _____ Last Name: _____
Street Address: _____ apt: _____
City: _____ State: _____ Zip: _____

Parent Information

First Name: _____ Last Name: _____
Phone: _____
Email: _____

Health History

Sex: _____ M/F DOB: _____ Age: _____
Height: _____ Weight: _____
Seizure Disorder Asthma Allergy
Orthopedic Injuries or Disorder:

Drug Sensitivity or Allergy:

Chronic Medical Problems:

Other Health Issues:

Medical Information

Name of Family Physician: _____ Phone: _____
Medical Insurance Company: Policy #: _____

Emergency Contact

Name Relationship Phone/cell _____
Name Relationship Phone/cell _____

Parent or Legal Guardian Must Complete the Following

I hereby certify that the above player is in good health and fully able to participate in all the activities associated with Achab Soccer Academy. I agree that Achab Soccer Academy and its directors will not be held responsible for any accident or loss to the participant however caused and hereby release Achab Soccer Academy from all claims or damages which may arise from any accident or loss.

I consent to have the administrators of Achab Soccer Academy act on my behalf should any emergency arise, and hereby grant permission to said administrators to authorize medical attention recommended by a physician, nurse, or hospital.

Print Name of Parent or Legal Guardian

Signature of Parent or Legal Guardian

Date