



## VIRGINIA VALOR FC MEDICAL RELEASE FORM

As the parent/legal guardian of \_\_\_\_\_, born on \_\_\_\_\_ I hereby give my consent and permission for the player named below to be medically and/or surgically treated for injuries and/or illness of any kind or seriousness under the direction of Team Officials with a valid USYS 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: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (Cell) \_\_\_\_\_

Person to notify if parent/guardian is unavailable:

Phone: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Group Number: \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_