FC DALLAS EMERALD COAST MEDICAL RELEASE FORM

I,_____________________________ (Parent/Guardian's Name) hereby give permission for any and all medical attention to be administered to my child ____________________________(Child's Name. In the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

ADDRESS:____

HOME PHONE:____

INSURANCE COMP:____

POLICY NUMBER:____

In case I cannot be reached, any of the following persons is designated to act on my behalf:

* COACH: ____

* MANAGER: ____

* A league representative where my child is playing.

* Any tournament representative where my child is participating in a tournament

PHYSICIAN: ____

ADDRESS: ____

PHONE: ____

KNOWN ALLERGIES:____

SIGNATURE
(PARENT/GUARDIAN)________________________DATE__________________

STATE OF FLORIDA
COUNTY OF ____

Sworn to (or affirmed) and subscribed before me this ____ day of ________ 20___, by _____________________________ who is personally known ____ or produced ________________________ as identification.

____
Signature Notary Public

(Print, Type, or Stamp Commissioned Name of Notary Public)