

CAMP HILL SOCCER CLUB

EMERGENCY MEDICAL INFORMATION AND TREATMENT RELEASE

Player Name: _____ Birthdate: _____

Address: _____

Home Phone: _____ Parent(s) Work Phone(s): _____

Insurance Company: _____ Policy Number: _____

In case of an emergency and a parent can not be contacted, please contact:

Name: _____ Phone Number: _____

Does your child wear glasses _____ or contacts _____

Does your child have any allergies? If yes, please list the allergies and treatment.

Does your child have asthma? If yes, list the symptoms and treatment.

Is your child on any medication? If yes, list the medication and dosage.

Are there any other medical conditions or previous injuries that the coach should be aware of?

In the event of an injury, I authorize my child's coach _____ to
arrange any necessary treatment.

Parent's signature: _____ Date: _____