

**CAMP HILL SOCCER CLUB**  
**2010 PLAYER INFORMATION AND MEDICAL RELEASE**

Player's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

**EMERGENCY INFORMATION** (Please include Area Code)

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_  
Father's Home Phone ( ) \_\_\_\_\_ Mother's Home Phone ( ) \_\_\_\_\_  
Father's Work Phone ( ) \_\_\_\_\_ Mother's Work Phone ( ) \_\_\_\_\_  
Father's Cell Phone ( ) \_\_\_\_\_ Mother's Cell Phone ( ) \_\_\_\_\_  
Father's E-Mail \_\_\_\_\_ Mother's E-mail: \_\_\_\_\_  
Person responsible for charges (if different from above) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

**In an emergency, when parent/guardian cannot be reached, please contact:**

Name: \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
Name: \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Other Medical Conditions: \_\_\_\_\_  
Date of last Tetanus Booster \_\_\_\_/\_\_\_\_/\_\_\_\_  
Player's Physician \_\_\_\_\_  
Work Phone: ( ) \_\_\_\_\_ 2<sup>nd</sup> Phone ( ) \_\_\_\_\_  
Medical and/or Hospital Insurance Company: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

Recognizing the possibility of physical injury associated with soccer and the consideration of the Camp Hill Soccer Club, and its affiliates accepting the Player for its soccer programs and activities (the "Programs), I hereby release, discharge and/or otherwise indemnify the Camp Hill Soccer Club, CPYSL and the USSF/USYS/EPYSA, and their respective affiliated organizations and sponsors, their employees and associated personnel, including the owner of fields and facilities utilized for the Programs against any claim by or on behalf of the Player as a result of the Player's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize.

As parent/legal guardian of the Player, I request that in my absence the above-named Player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentist, and staff, duly licensed as Doctors of Medicine/Osteopath or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above Player. I have not been given a guarantee as to the result of examination or treatment. I agree to be responsible financially for the reasonable cost of each assistance and/or treatment.

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

**Date** \_\_\_\_\_