Westchester United FC

Medical Release Authorization Form 2017/2018

Release

I, the undersigning, am the parents or legal guardian of the registrant, OR I am the registrant, age 18 or older, hereby agrees that the registrant will abide by the rules of Westchester United FC, and its affiliated organization and sponsors. Recognizing that soccer is a rigorous sport and the possibility of physical injury associated with soccer and in consideration for Westchester United FC and its affiliated organizations accepting the registrant for its soccer programs and activities (the "Program"), I hereby release, discharge and/or otherwise indemnify Westchester United FC, and its affiliated organizations and sponsors, their employees and associated personnel, including team coaches, game officials, and the owners of the fields and facilities utilized for "the Programs", against any claim by or on behalf of the registrant, as a result of the registrant's participation in "the Program" and/or being transported to or from the same, which transportation I hereby authorize.

Medical Authorization

I, the undersigning, am the parent or legal guardian of the registrant, OR I am the registrant, age 18 or older, do hereby give my permission for the registrant to receive any and all medical treatment, assistance, or care administered by a duly licensed physician or hospital in the even of an injury, accident, or sickness while he is being transported to, or is attending nay game or other event conducted or sponsored by Westchester United FC, or its affiliated organizations, until, such time as I may be contacted. I also hereby assume responsibility for the payment of any such treatment.

Players Name: ____

Representing Club/Team: Westchester United FC **Date of Birth:** ____________

Home Address: ____

Home Phone: ____________

Emergency Contact: _______________________ **Relationship:** ___________

Allergies/Medical Conditions: ____

Physician's Name/Phone: ____

Medical/Insurance Co:____

Policy Number:____

I confirm that the registrant named above is covered by the above medical insurance policy. I further state that I have carefully read the foregoing release and medical authorization and agree to and understand the content thereof.

Parent Signature: __________________________________ **Date:** ______________

THIS FORM **MUST** BE NOTARIZED BELOW

Sworn to and subscribed before me this _____________ day of ___________________, 20_____.

I am a notary public of ______________________, (county), in the state of: _______________.

My commission expires on the _____________ day of _________________________________

Notary Signature: ____