



Columbus Express Soccer Club

As the parent/legal guardian of _____, I Request that in my absence the above named player be admitted to any hospital facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine 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 minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

This instrument of consent to authorize medical attention shall be in effect as of the date given below. This shall remain in force only until such time as I am contacted and able to assume such responsibility for the care of my child. I will be responsible for any and all fees and/or costs incurred as a result of this authorization.

In signing this document, I also understand that any and all personnel associated with Columbus Express Soccer Club shall not held liable for any injury whatsoever my child may sustain in the activities thereof.

Name of Player		
Player's Date of Birth		
Date of last Tetanus Booster		
Known allergies (incl. medical)		
Medical Issues to be noted		
Family Physician	name:	phone:
Parent/Guardian	name:	
	address:	city:
	state/zip	home phone:
	cell phone:	work phone:
Person responsible for charges (if different from above)	name:	
	address:	city:
	state/zip:	home phone:
	cell phone:	work phone:
Emergency contact (if parent/guardian is unavailable)	name:	
	address:	city:
	state/zip:	home phone:
	cell phone:	work phone:

Signature of Parent/Guardian: _____

JURAT

State of _____

County of _____

Sworn to and subscribed before me on the ____ day of _____, 20____.

Notary Public in and for State of _____ Commission Expires _____