# Auburndale Youth Soccer Club Scream

Post Office Box 1749 Auburndale, FL 33823 (863) 965-2972

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: _____
* ASST.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 _____

Subscribed and sworn before me,

this _____ day of _____ , 201_

_____

Notary Public