

CHALLENGE® SOCCER CLUB MEDICAL RELEASE

This is to certify that my daughter, _____, has my permission to participate in soccer training, tournaments, and games with the Challenge® Soccer Club in various locations in the United States. I understand that airline, automobile, and other means of travel to and from these events will be necessary. As the parent or legal guardian of the above-named 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, dentists and staff, duly licensed as Doctors of Medicine or Doctor of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-rays treatments and anesthetics as may be necessary in the diagnosis and treatment of the above minor. I have not been given a guarantee as to the results of the examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above named person.

DATE OF CHILD'S BIRTH _____ DATE OF LAST TETANUS BOOSTER _____

KNOWN ALLERGIES OF CHILD (INCLUDING MEDICATION) _____

MY CHILD HAS THE FOLLOWING MEDICAL PROBLEM(S) WHICH SHOULD BE NOTED: _____

FAMILY PHYSICIAN _____ PHONE # _____

NEXT OF KIN TO NOTIFY _____ PHONE # _____

CLOSE FRIEND _____ PHONE # _____

PERSON RESPONSIBLE FOR CHARGES _____

MAILING ADDRESS _____

CITY, STATE, ZIP CODE _____

HOME PHONE # _____ WORK PHONE # _____

PRIMARY INSURANCE CARRIER _____

POLICY NUMBER _____

SECONDARY INSURANCE CARRIER _____

POLICY NUMBER _____

In witness of our consent and agreement to the medical authorization specified herein, we have subscribed our signatures on this _____ day of _____, 20_____.

Parent/Guardian

Parent/Guardian

STATE OF TEXAS
COUNTY OF HARRIS

Subscribed and sworn to before me, the undersigned NOTARY PUBLIC, this _____ day of _____, 20_____.

Notary Public in and for the State of Texas