

# CASL

# 2007 TOURNAMENT SERIES

## 2007 CASL SHOOTOUT PLAYER MEDICAL RELEASE FORM

PLAYER'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### EMERGENCY INFORMATION

MOTHER'S NAME \_\_\_\_\_ HM PH (\_\_\_\_) \_\_\_\_\_ Cell PH (\_\_\_\_) \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_ HM PH (\_\_\_\_) \_\_\_\_\_ Cell PH (\_\_\_\_) \_\_\_\_\_

### IN AN EMERGENCY WHEN PARENTS CANNOT BE REACHED, PLEASE CONTACT:

NAME \_\_\_\_\_ HM PH (\_\_\_\_) \_\_\_\_\_ Cell PH (\_\_\_\_) \_\_\_\_\_

NAME \_\_\_\_\_ HM PH (\_\_\_\_) \_\_\_\_\_ Cell PH (\_\_\_\_) \_\_\_\_\_

ALLERGIES \_\_\_\_\_

OTHER MEDICAL CONDITIONS \_\_\_\_\_

PLAYERS PHYSICIAN \_\_\_\_\_ HM PH (\_\_\_\_) \_\_\_\_\_ WK PH (\_\_\_\_) \_\_\_\_\_

MEDICAL AND/OR HOSPITAL INS. CO. \_\_\_\_\_ PH (\_\_\_\_) \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_ POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

### PARENTS APPROVAL AND MEDICAL RELEASE

RECOGNIZING THE POSSIBILITY OF PHYSICAL INJURY ASSOCIATED WITH SOCCER AND IN CONSIDERATION FOR THE CASL SHOOTOUT AND ITS AFFILIATES ACCEPTING THE REGISTRANT FOR ITS SOCCER TOURNAMENT AND ACTIVITIES, I HEREBY RELEASE, DISCHARGE, AND/OR OTHERWISE INDEMNIFY THE CASL SHOOTOUT, IT'S AFFILIATED ORGANIZATIONS AND SPONSORS, THEIR EMPLOYEES AND ASSOCIATED PERSONNEL, INCLUDING THE OWNERS OF FIELDS AND FACILITIES UTILIZED FOR THE TOURNAMENT AGAINST ANY CLAIM BY OR ON BEHALF OF THE REGISTRANT AS A RESULT OF THE REGISTRANT'S PARTICIPATION IN THE TOURNAMENT.

MY SON/DAUGHTER HAS RECEIVED A PHYSICAL EXAMINATION BY A PHYSICIAN AND HAS BEEN FOUND PHYSICALLY CAPABLE OF PARTICIPATING IN THE TOURNAMENT. I HEREBY GIVE CONSENT TO HAVE AN ATHLETIC TRAINER AND /OR DOCTOR OF MEDICINE OR DENTISTRY PROVIDE MY SON/DAUGHTER WITH MEDICAL ASSISTANCE AND/OR TREATMENT AND AGREE TO BE RESPONSIBLE FINANCIALLY FOR THE REASONABLE COST OF SUCH ASSISTANCE AND/OR TREATMENT.

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

SUBSCRIBED AND SWORN TO BEFORE ME THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_

NOTARY PUBLIC \_\_\_\_\_ MY COMMISSION EXPIRES \_\_\_\_\_

(RAISED SEAL OR ORIGINAL STAMP - NOTARY SEAL IS MANDATORY)