RELEASE AND CONSENT FOR MEDICAL TREATMENT

I, the parent/guardian of the player ("Player") specified below, a minor, agree that the Player and I will abide by the rules of Lake Highlands Soccer Association ("LHSA") and United States Youth Soccer Association ("USYSA"), its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer and in consideration of the LHSA and USYSA accepting the Player for their soccer program and activities (the "Program"), I hereby release, discharge and/or otherwise indemnify LHSA and USYSA, their affiliated organizations and sponsors, their employees, volunteers and associated personnel, including the owners of fields and facilities utilized for the Program, against any claim by or on behalf of the Player or the undersigned parent/guardian as a result of the Player's participation in the Program and/or being transported to or from the same, which transportation I hereby authorize.

I request that in my absense the 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 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 Player, a minor, to preserve the life, limb or well-being of the Player. 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 take from the Player.

Name of Player:____

List any medical problem/prohibition or allergies:______________________________

Player's Doctor: ______________________________ Telephone: ______________

Player's Parents/Guardian:______________________________________

Address:____

Phone: Home:____________________ Work:______________________

Person responsible for charges (if different from above):______________________

Address:____

Phone: Home:____________________ Work:______________________

Person to notify if parent/guardian unavailable:____________________________

Address:____

Phone: Home:____________________ Work:______________________

Medical and/or Hospital Insurance Co.:____________________________________

Policy Holder: ____________________ Policy Number: ____________________

Signature of Parent/Guardian:______________________

Printed Name of Parent/Guardian:____________________

STATE OF TEXAS)
)
COUNTY OF DALLAS)

SUBSCRIBED AND SWORN TO before me this _____ day of ____________, 20___.

____
Notary Public, State of Texas