

**ARLINGTON TRAVEL SOCCER CLUB  
Consent and Medical Authorization Form**

As the parent/legal guardian of \_\_\_\_\_, 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 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.

Date of Player's birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last tetanus booster \_\_\_\_/\_\_\_\_/\_\_\_\_

Known Medical Problems/Allergies: \_\_\_\_\_  
\_\_\_\_\_

Parents/Guardian \_\_\_\_\_

Address \_\_\_\_\_

Phones Home \_\_\_\_\_ Office (M) \_\_\_\_\_ (F) \_\_\_\_\_  
\_\_\_\_\_

Cell (M) \_\_\_\_\_ (F) \_\_\_\_\_ Fax \_\_\_\_\_

Family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Person responsible for charges (if different from above) \_\_\_\_\_

Address \_\_\_\_\_

Phones Home \_\_\_\_\_ Office \_\_\_\_\_ (Cell) \_\_\_\_\_  
\_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Address for Submitting Claims \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date Signed

\*Subscribed and Sworn to me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_

Notary \_\_\_\_\_

My Commission expires \_\_\_\_\_

\*Notarization is not required by US Youth Soccer