



CHARIHO YOUTH SOCCER ASSOCIATION

P.O. Box 1207, Hope Valley, RI 02832 1-800-788-9972

Medical/Release Waiver

Every coach needs to have this with him or her at all times in the event of an emergency.

Player's Name: _____

Player's Address: _____

Date of Birth: _____

Home Phone: _____

Parent #1 _____

Phone Number: _____

Parent #2 _____

Phone Number: _____

Medical Conditions: _____

Known Allergies: _____

Medical Insurance: _____

Policy Holder: _____

Player's Doctor: _____

Phone Number: _____

In an emergency, when parents cannot be reached please contact:

Name: _____ Phone: _____

Recognizing the possibility of injury or illness, and in consideration for the US Youth Soccer, Soccer Rhode Island, Rhode Island Youth Super Liga and its members, accepting my son/daughter as a player in the soccer programs and activities of the above mentioned organizations, I consent to my son/daughter participating in the programs. Further, I release, discharge, and otherwise indemnify US Youth Soccer, Soccer Rhode Island, Rhode Island Youth Super Liga, its members, sponsors, their employees, associated personnel, and volunteers, including the owner of fields and facilities utilized for the programs, against any claim by or on behalf of my player son/daughter as a result of my son's/daughter's participation in the programs and or being transported to or from the programs which transportation I authorize.

My player son/daughter has received a physical examination by a physician and has been found physically capable of participating in the programs. I have provided written notice, which was submitted in conjunction with this release and attached hereto, setting forth any specific issue, condition or ailment, in addition to what is specified above, that my child has or that may impact my child's participation in the programs. I give my consent to have an athletic and or doctor of medicine or dentistry provides my son/daughter with medical assistance and or treatment and agree to be responsible financially for the reasonable cost of each assistance and or treatment

Signature of Parent/Guardian

Date