

NORTHERN INDIANA FUTBOL ACADEMY

Please fill out clearly and completely!



Medical Release Form

Name: _____ Team Age: _____ Girl or Boy
Social Security Number: _____ Birth Date: _____
Parent E-Mail _____
Address: _____ City/State: _____ Zip: _____
Home Phone: _____ Father's Name & Work Phone: _____
Father's CELL # _____ Mother's Name: _____ (CELL#) _____
Insurance Company Name & Address: _____
Insurance Policy #: _____ Group#: _____ Date of last tetanus shot: _____
Player's Primary Care Physician's Name: _____
Physician's Address: _____ Phone #: _____
Known Allergies or other Medical Problems: _____

PARENT'S APPROVAL AND MEDICAL RELEASE:

RECOGNIZING THE POSSIBILITY OF PHYSICAL INJURY ASSOCIATED WITH SOCCER AND IN CONSIDERATION FOR THE JR. IRISH SOCCER CLUB/NIFA AND IT'S AFFILIATES ACCEPTING THE REGISTRANT FOR IT'S SOCCER PROGRAMS AND ACTIVITIES (THE "PROGRAMS"), I HEREBY RELEASE, DISCHARGE AND/OR OTHERWISE INDEMNIFY THE JR. IRISH SOCCER CLUB/NIFA, IT'S AFFILIATED ORGANIZATIONS AND SPONSORS, THEIR EMPLOYEES AND ASSOCIATED PERSONNEL, ORGANIZATIONS AND SPONSORS, THEIR EMPLOYEES AND ASSOCIATED PERSONNEL, INCLUDING THE OWNERS OF FIELDS AND FACILITIES UTILIZED FOR THE PROGRAMS AGAINST ANY CLAIM BY OR ON BEHALF OF THE REGISTRANT AS A RESULT OF THE REGISTRANTS PARTICIPATION IN THE PROGRAMS AND/OR BEING TRANSPORTED TO OR FROM THE SAME, WHICH TRANSPORTATION I HERBY AUTHORIZE.

MY SON/DAUGHTER HAS RECEIVED A PHYSICAL EXAMINATION BY A PHYSICIAN AND HAS BEEN FOUND PHYSICALLY CAPABLE OF PARTICIPATING IN THE PROGRAMS.

I REPRESENT THAT I AM GUARDIAN OF _____, HERINAFTER REFERRED TO AS "MY CHILD", A MEMBER OF A JR. IRISH SOCCER CLUB/NIFA SOCCER TEAM. AS GUARDIAN OF MY CHILD AND WITH FULL AUTHORITY TO DO SO, I HEREBY DESIGNATE _____, COACH OR _____, MANAGER, AND EACH OF THEM, AS MY ATTORNEY-IN-FACT TO OBTAIN MEDICAL TREATMENT AT MY EXPENSE FOR MY CHILD. THE AUTHORITY HEREBY CONFERRED MAY BE EXERCISED BY ONE OR MORE OF THE FOREGOING NAMED INDIVIDUALS AND SHALL INCLUDE ALL OF THE POWER I POSSESS AS A NATURAL GUARDIAN TO OBTAIN MEDICAL TREATMENT FOR MY CHILD. THE POWER GRANTED HEREIN INCLUDES THE POWER TO OBTAIN TREATMENT FROM PHYSICIANS, HOSPITALS AND OTHER HEALTH CARE PROVIDERS AND THE RIGHT TO TAKE ANY ACTION WHICH, IN THE DISCRETION OF THE PERSON EXERCISING IT, SEEMS REASONABLE UNDER THE CIRCUMSTANCES. IN EXERCISING THE AUTHORITY GRANTED BY THIS INSTRUMENT, THE ATTORNEY-IN-FACT SHALL EXERCISE HIS OR HER DISCRETION MAKING SUCH DECISIONS AS HE OR SHE DEEMS ADVISABLE GIVING DUE CONSIDERATION TO MY CHILD'S MEDICAL NEEDS. THIS GRANT OF AUTHORITY SHALL NOT CREATE AN OBLIGATION IN ANY PERSON TO OBTAIN MEDICAL TREATMENT AND SHALL NOT IMPLY ANY LIABILITY TO SUCH PERSON FOR THE FAILURE TO OBTAIN MEDICAL TREATMENT OR FOR ANY INJURIES SUSTAINED BY MY CHILD AS A RESULT OF SUCH TREATMENT.

SIGNATURE OF PARENT/GUARDIAN DATE

Subscribed and sworn to before me this _____ day of _____, 20_____

Notary Seal Mandatory Here! _____ Notary Public
Resident of _____ County