

**TROY RECREATION ASSOCIATION, INC.**  
**11 N. MARKET ST.**  
**TROY, OH 45373**  
**937-339-1923**

**INDOOR SOCCER**

MEDICAL TREATMENT RELEASE 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.

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

Has your child had a Tetanus booster shot? \_\_\_\_\_

Known allergies of this player, including any allergies to medicine \_\_\_\_\_  
\_\_\_\_\_

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

Insurance Carrier \_\_\_\_\_

Name of parent/guardian \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell or other)

Person to notify if parent/guardian is unavailable \_\_\_\_\_

Phone \_\_\_\_\_ Alternate phone \_\_\_\_\_

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