



California Youth Soccer Association Emergency Medical Consent Form

I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Dentistry for:

_____ (PLEASE PRINT LAST NAME, FIRST NAME) as it appears on Birth certificate-NO NICK NAMES

as his/her parent or legal guardian. This care may be given under whatever conditions are necessary to preserve life, limb or well being of my dependent. I also hereby release the California Youth Soccer Association, Inc. and affiliated organizations and personnel, owners of fields and facilities used by the Olympic Development Program against any claim by or on behalf of registrant as a result of the registrant's participation in the Program, and/or being transported to and from, which transportation I hereby authorize.

Signature of Parent or Legal Guardian

Please print name of Parent or Legal Guardian

Date

PLEASE PRINT LEGIBLE, THIS IS IMPORTANT INFORMATION

PLEASE PRINT: LAST NAME, FIRST NAME			
<i>Please check this box if you have had an address change in the last 6 months. Otherwise, leave blank.</i>			
Name:		M	F
		Date of Birth:	
Address:		City:	
		Zip:	
Home Phone:		Cell Phone:	
Player Email:			
Medical Insurance carrier:			
Medical Card Number: (Do not send a copy of card)			
Club Team:		Coach:	
PLEASE PRINT: LAST NAME, FIRST NAME			
Address:		Address:	
Day Phone:		Evening Phone:	
Email:		Cell Phone:	
Address:		Address:	
Day Phone:		Evening Phone:	
Email:		Cell Phone:	

