



Michigan State Youth Soccer Association

# OFFICIAL MSYSA FORM



THIS FORM MUST BE PRINTED OR TYPED  
MSYSA STATE OFFICE - 9401 GENERAL DRIVE, SUITE 120, PLYMOUTH, MI 48170.

## SOCCER MEDICAL RELEASE

I hereby give my permission for any and all medical attention necessary to be administered to my child,

(INSERT CHILD'S NAME)

In the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted, this release is effective for a period of one year from the date given below. I also assume the responsibility for the payment of any such treatment, including, but not limited to transportation for required treatment.

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Agent: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Type: \_\_\_\_\_

In case I cannot be reached, any of the following people are designated to act on my behalf:

- 1. Coach
- 2. Assistant Coach/Manager
- 3. Team Parent
- 4. A league representative where my child is playing
- 5. Any tournament representative where my child is participating in a US Youth sanctioned tournament.

In case I cannot be reached, please call \_\_\_\_\_ at \_\_\_\_\_

Our Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Hospital: \_\_\_\_\_

Known Allergies: \_\_\_\_\_

Known Disabilities: \_\_\_\_\_

Other Important Medical Information: \_\_\_\_\_

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