

WEST HILLS JUNIOR SOCCER CLUB

Consent for Medical Treatment:

As the parent/guardian of, _____ (player's name), I certify that the registrant is in good physical condition and I have no knowledge of any physical condition, injury or illness whatsoever that would place my child at risk while participating in West Hills Soccer programs. I also hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve life, limb or well being of the registrant.

Medical problems or prohibitions _____

Known allergies _____

Family Physician _____

Phone _____

Health Insurance Provider _____

Policy and Group # _____

Emergency Contact _____ Relationship _____

Phone _____

Print parent's/guardian's name _____

Home phone _____ Work _____ Cell/other _____

E-mail address _____

Parent/guardian signature _____

Date _____