

**FC NOVA SOCCER CLUB  
MEDICAL RELEASE FORM**

Coach's copy – To be carried by coach to **all** games and practices

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**Player Information:**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

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**Parent/Guardian 1 Information:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

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**Parent/Guardian 2 Information:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

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**Emergency Information:**

Person to Notify In Case of Emergency: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Doctor to Notify in Emergency: \_\_\_\_\_ Phone: \_\_\_\_\_  
Hospital Preference, if any: \_\_\_\_\_ City: \_\_\_\_\_  
List Any Medical Problems or Conditions Player Has (include allergies and medications currently taking):  
\_\_\_\_\_  
\_\_\_\_\_

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**Family Insurance Carrier Information:**

Insurance Company: \_\_\_\_\_ Child's Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Do You Have a Dental Program? \_\_\_\_\_  
Subscriber Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Subscriber Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_  
Subscriber Prescription Drug Number: \_\_\_\_\_

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FC NOVA has adopted Rules and Regulations that are available at registration and from the Secretary at any reasonable time. By signing this form for a child, any parent, guardian or other person consents for himself or for any child participating in the FC NOVA program to being subject to the Rules and Regulations of FC NOVA as such rules apply to any child's play and a parent's participation as a spectator, coach, or FC NOVA volunteer. The undersigned does further authorize the officer, leader, coach or agent(s) of the FC Nova Soccer Club program to transport as required the above Minor to and from Associated-sponsored activities including but not limited to athletic and social events.

I also hereby give my consent for all medical care prescribed by a duly licensed Doctor of Medicine for the above minor as his/her parent or legal guardian. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of my dependent. To the best of the undersigned knowledge all of the above information is true and accurate.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_