

## PARENT/GUARDIAN CONSENT AND PLAYER MEDICAL RELEASE FORM

Player's Name: Drake Cecil	Date of 1	<sub>ler:</sub> Boys		
Address: 7352 Charrington D				
EMERGENCY INFORMATION	,			•
Father's Name: James Cecil	Home Phone:	734-740-2354	Work Phone:	734-740-2354
Mother's Name: Christina Cecil	Home Phone:	734-740-1913	Work Phone:	734-740-1913
In an emergency, when parents cannot				
Name: Theresa Stacy	Home Phone:	734-765-5473	Work Phone:	734-765-5473
Name: Patrick Cecil				
Allergies: Penicillin				
Other Medical Conditions: Non				
Player's Physician: Dr Christine Brenr	ner Home Pho	734-853-569	4 _ Work Phone	734-853-5694
Medical and/or Hospital Insurance Compa	Blue Cr	oss Blue Shie	ld <sub>Phone:</sub> 80	0-521-0488
Policy Holder: James Cecil				
MSYSA Does NOT rea				

## PLEASE COPY BOTH SIDES OF YOUR HEALTH INSURANCE CARD AND ATTACH TO THIS FORM

## PARENT/GUARDIAN CONSENT AND MEDICAL RELEASE

Recognizing the possibility of injury or illness, and in consideration for US Youth Soccer and members of US Youth Soccer accepting my son/daughter as a player in the soccer programs and activities of US Youth Soccer and its members (the "Programs"), I consent to my son/daughter participating in the Programs. Further, I hereby release, discharge, and otherwise indemnify US Youth Soccer, its member organizations and sponsors, their employees, associated personnel, and volunteers, including the owner of fields and facilities utilized for the Programs, against any claim by or on behalf of my player son/daughter as a result of my son's/daughter's participation in the Programs and/or being transported to or from the Programs. I hereby authorize the transportation of my son/daughter to or from the Programs.

My player son/daughter has received a physical examination by a licensed medical doctor and has been found physically capable of participating in the sport of soccer. I have provided written notice, which is submitted in conjunction with this release and attached hereto, setting forth any specific issue, condition, or ailment, in addition to what is specified above, that my child has or that may impact my child's participation in the Programs. I give my consent to have an athletic trainer and/or licensed medical doctor or dentist provide my son/daughter with medical assistance and/or treatment and agree to be financially responsible for the reasonable cost of any such assistance and/or treatment.

Christina Cecil	/	I understand that checking this box constitutes a legal		02/28/23	
Signature of Parent/Guardian	1	signature	·	Date	