



PARENT/GUARDIAN CONSENT AND PLAYER MEDICAL RELEASE FORM

Player's Name: Drake Cecil Date of Birth: 06/01/12 Gender: Boys
Address: 7352 Charrington Dr City: Canton State: MI Zip: 48187

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 be reached, please contact:

Name: Theresa Stacy Home Phone: 734-765-5473 Work Phone: 734-765-5473
Name: Patrick Cecil Home Phone: 313-802-6020 Work Phone: 313-802-6020

Allergies: Penicillin

Other Medical Conditions: Non

Player's Physician: Dr Christine Brenner Home Phone: 734-853-5694 Work Phone: 734-853-5694

Medical and/or Hospital Insurance Company: Blue Cross Blue Shield Phone: 800-521-0488

Policy Holder: James Cecil Policy #: Dxp 922514855 Group #:

MSYSA Does NOT require a copy of the health insurance card

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 signature

02/28/23

Signature of Parent/Guardian

Date