



PARENT/GUARDIAN CONSENT AND PLAYER MEDICAL RELEASE FORM

Player's Name: Annabella Shall Date of Birth: 02/07/12 Gender: Girls
Address: 45455 Harmony Lane City: Belleville State: MI Zip: 48111

EMERGENCY INFORMATION

Father's Name: David Shall Home Phone: 734-355-0055 Work Phone: 734-355-0055
Mother's Name: Angela Shall Home Phone: 734-308-4821 Work Phone: 734-308-4821

In an emergency, when parents cannot be reached, please contact:

Name: Carole Durant Home Phone: 734-464-8222 Work Phone: 734-945-3800
Name: Jim Ford Home Phone: 734-776-3030 Work Phone: 734-776-3030

Allergies: None

Other Medical Conditions: No

Player's Physician: Susan Stevens Home Phone: 734-462-0090 Work Phone: 734-462-0090

Medical and/or Hospital Insurance Company: Cofinity Phone: 809-831-1166

Policy Holder: David Shall Policy #: 0106000081 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.

Signature of Parent/Guardian



I understand that
checking this box
constitutes a legal
signature

07/03/23

Date