



PARENT/GUARDIAN CONSENT AND PLAYER MEDICAL RELEASE FORM

Player's Name: Aadian Kreitner Date of Birth: 11/20/14 Gender: Boys
Address: 33460 Beechwood St. City: Canton State: MI Zip: 48185

EMERGENCY INFORMATION

Father's Name: Shawn Wylie Home Phone: 313-992-5966 Work Phone: 313-992-5966
Mother's Name: Sabrina Kreitner Home Phone: 734-444-7611 Work Phone: 734-444-7611

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

Name: Shawn Wylie Home Phone: 313-992-5966 Work Phone: 313-992-5966
Name: Sabrina Kreitner Home Phone: 734-444-7611 Work Phone: 734-444-7611

Allergies: None

Other Medical Conditions: None

Player's Physician: Dr Olsen Home Phone: 734-844-5400 Work Phone: 734-844-5400

Medical and/or Hospital Insurance Company: Meridean Phone: 888-437-0606

Policy Holder: Aadian kreitny Policy #: 1146126027 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

05/20/25

Date