



PARENT/GUARDIAN CONSENT AND PLAYER MEDICAL RELEASE FORM

Player's Name: Robert Welsh Date of Birth: 01/17/13 Gender: Boys
Address: 43905 Cranford Avenue City: Canton State: MI Zip: 48187

EMERGENCY INFORMATION

Father's Name: Christopher J Welsh Home Phone: 734-502-6338 Work Phone: 734-502-6338
Mother's Name: Lacey S Welsh Home Phone: 517-402-4202 Work Phone: 517-402-4202

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

Name: Regina Wilson Home Phone: 517-944-4222 Work Phone: 517-944-4222
Name: Allison Burke Home Phone: 734-556-2574 Work Phone: 734-556-2574

Allergies: N/A

Other Medical Conditions: N/A

Player's Physician: Dr. Victoria Home Phone: 734-398-7899 Work Phone: 734-398-7899

Medical and/or Hospital Insurance Company: Blue Cross Blue Shield Michigan Phone: 800-482-2210

Policy Holder: Christopher J Welsh Policy #: GMJ911619234 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: Christopher J Welsh Date: 05/20/25



I understand that checking this box constitutes a legal signature