

**KINZUA SOCCER CLUB**  
**RELEASE, TRAVEL, PERMISSION, AND MEDICAL AUTHORIZATION**

I, the undersigned parent or natural guardian of \_\_\_\_\_ a minor, understand that she/he is about to become a participant in a soccer program sponsored by the Kinzua Soccer Club. I understand that there are certain risks of injury associated with playing soccer and I agree to assume those risks. I believe that my daughter/son is in proper physical condition to participate in this sport. I understand further that it is my obligation to have her/him undergo a physical examination prior to participation in this sport to determine her/his fitness. I hereby release and forever discharge the Club, its members, officers, coaches, and employees from any and all liability, including liability for antecedent negligence, for injury to my daughter/son by reason of her/his participation in the sport of soccer with the Club. I understand that the Club is not providing any insurance for our daughter/son and if she/he sustains injury, it will be solely my responsibility to provide and pay for any medical treatment required. I agree to indemnify and hold harmless the Club, its members, officers, coaches and employees from any and all liability they may incur on account of my daughter's/son's participation in the program, to her/him or any other person. In the event of injury or illness involving my daughter/son, I authorize the coaches or other representatives of the Club to arrange for and consent to on my behalf, any required medical treatment.

I certify that my daughter/son has permission to travel with the Club to soccer tournaments, games and other activities by the Club's chosen means of travel from August 1, 2009 to July 31, 2010. My daughter/son has the following medical problems which should be noted:

\_\_\_\_\_  
My daughter/son has the following allergies which should be noted:

\_\_\_\_\_  
My medical coverage company name and policy number is:

\_\_\_\_\_  
In case of emergency, I can be reached at:

Home# ( ) \_\_\_\_\_ . Work # ( ) \_\_\_\_\_ .

Nearest friend or relative you can contact in emergency should you be unable to reach me is:

Name: \_\_\_\_\_ . Phone: ( ) \_\_\_\_\_ .

Family Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ .

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ .

Signature