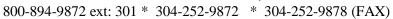


WEST VIRGINIA SOCCER ASSOCIATION

PO BOX 3360 – BECKLEY, WV 25801





Web: www.wvsoccer.net Email: cups@wvsoccer.net

MEDICAL RELEASE FORM

Function:				
Players Name:			_ U.S. Citizen: Yes	_ No
Address:				
City/ State/ Zip Code:				
Birth date:	Sex:	Social Security Number:		
Parent's Phone: Home: ()		Cell: ()		
Emergency phone number other	r than Par	ent/ Guardian:		
Name:		Phone: ()		
Primary Medical Insurance Cor	npany:			
Policy Number:				
Known allergies or other potent	ial medica	l information:		
				_
				_
				_
Recognizing the possibility of pland its affiliates accepting the received and its affiliates accepting the received and its affiliates and/or otherwemployees and associated person Programs, against any claim by being transported to or from the physical examination by a physiprograms.	egistrant for vise indem nnel, include or on beha e same, wh	or its soccer programs and acti mify USYS/USS, its affiliated o ding the owners of fields and fa alf of the registrant's participa nich transportation I hereby au	vities (the "Programs rganizations and spon acilities utilized for the tion in the Programs athorize. My child has	") I hereby asors, their e and/or s received a
Therefore, I grant as my surrogate for my child in dentistry. I also assume the fina	the area of	f obtaining medical treatment	by a doctor of medicin	
Signature of Parent/ Guardian:		D	ate:	
Subscribed and sworn to me thi	s	Day o	f	
SignatureNotary Public	:	My commission expires _		