

SCARBOROUGH FOOTBALL CLUB
MEDICAL RELEASE FORM
(Please return this form to your Division Coordinator)

Athlete's Name: _____ Birth Date: _____

Parent/Guardian Authorization:

Parent/Guardian Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Email*: _____

*All communication will be sent via e-mail.

Emergency Contact (other than parent):

Name: _____ Phone: _____

Relationship to athlete: _____

Physician Information:

Family Physician: _____ Phone: _____

In case of an emergency, if family physician cannot be reached, I hereby authorize

(Name of athlete) _____ to be treated by another qualified physician who is available.

Allergies: _____

Date of last tetanus booster: _____ Date of last physical: _____

Insurance information:

Insurance Company: _____

Subscriber Name: _____

Policy/ID Number: _____

Group Number: _____

Parent/Guardian Signature: _____

Date: _____