

**Medical Release**  
**Long Island FSHD Foundation**  
**Soccer Clinic Fundraiser**

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Player's name: \_\_\_\_\_ U.S. Citizen: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ M/F: \_\_\_\_\_ SS#: \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

**Emergency Contact Other Than Parent/Guardian:**

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

Primary Medical Insurance Company:

Policy  
Number: \_\_\_\_\_

**Known Allergies or Other Pertinent Medical Information:**

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Recognizing the possibility of physical injury associated with soccer and in consideration for Long Island FSHD Foundation and its affiliates accepting the registrant for its soccer program and activities (the Programs) I hereby release, discharge and/or otherwise indemnify Long Island FSHD Foundation, its affiliated organizations and sponsors, their associated personnel, including the owners of fields and facilities utilized for the Programs against any claim by or on behalf of the registrant's participation in the Programs. My child has received a physical examination by a physician and has been found physically capable of participating in the Programs.

Therefore, I grant \_\_\_\_\_ and/or \_\_\_\_\_ permission to act as my surrogate for my child in the area of obtaining medical treatment by a doctor of medicine or dentistry. I also assume financial responsibility for any medical treatment for my child.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_