

**Medical Release Form**  
**Achab Soccer Academy**

**Player Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ apt: \_\_\_\_\_

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

**Parent Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**Health History**

Sex: \_\_\_\_\_ M/F      DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Seizure Disorder       Asthma       Allergy

Orthopedic Injuries or Disorder:

\_\_\_\_\_  
\_\_\_\_\_

Drug Sensitivity or Allergy:

\_\_\_\_\_  
\_\_\_\_\_

Chronic Medical Problems:

\_\_\_\_\_  
\_\_\_\_\_

Other Health Issues:

\_\_\_\_\_  
\_\_\_\_\_

**Medical Information**

Name of Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance Company: Policy #: \_\_\_\_\_

**Emergency Contact**

Name Relationship Phone/cell \_\_\_\_\_

Name Relationship Phone/cell \_\_\_\_\_

**Parent or Legal Guardian Must Complete the Following**

I hereby certify that the above player is in good health and fully able to participate in all the activities associated with Achab Soccer Academy. I agree that Achab Soccer Academy and its directors will not be held responsible for any accident or loss to the participant however caused and hereby release Achab Soccer Academy from all claims or damages which may arise from any accident or loss.

I consent to have the administrators of Achab Soccer Academy act on my behalf should any emergency arise, and hereby grant permission to said administrators to authorize medical attention recommended by a physician, nurse, or hospital.

\_\_\_\_\_  
Print Name of Parent or Legal Guardian

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date