WEST HEMPSTEAD
CHIEFS SOCCER CLUB
BOX 494 • WEST HEMPSTEAD, NY 11552 • (516) 733-4409

# Medical Release Form

I hereby give my authorization and consent to any supervising representative of the West Hempstead Chiefs Soccer Club to cause medical attention to be administered to my child _____in the event of an accident, injury, sickness or other medical problems. This authorization and consent shall take effect immediately. I agree that I will solely and personally be responsible for payment of all such medical attention.

My address is: _____

Phone: (Home) _____ Phone: (Office) _____

In the event I cannot be reached, please contact:

Name: _____ Phone: _____

Physicians Name: _____ Phone: _____

Allergies: _____

Medications: _____

Medical Conditions: _____

Parent's Signature _____ Date_____

Sworn to and subscribed before me on the _____day of _____

Notary Public:
State of _____
County of_____