PLAYER MEDICAL RELEASE FORM

Player's Name: _____ Date of Birth: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION:

Parent/Guardian Name: _____ Home Phone: _____ Work Phone: _____

Parent/Guardian Name: _____ Home Phone: _____ Work Phone: _____

In an emergency, when parents/guardians cannot be reached, please contact:

Name: _____ Home Phone: _____ Work Phone: _____

Name: _____ Home Phone: _____ Work Phone: _____

Allergies: _____

Other Medical Conditions: _____

Player's Physician: _____ Office Phone: _____

Medical and/or Hospital Insurance Company: _____ Phone: _____

Policy Holder: _____ Policy #: _____ Group #: _____

PARENT/GUARDIAN CONSENT AND MEDICAL RELEASE

Recognizing the possibility of injury or illness, and in consideration for Elite Tournaments and Southampton Football Club accepting my son/daughter as a player in the soccer programs and activities of the Southampton Player ID Tour and its members (the "Programs"), I consent to my son/daughter participating in the Programs. Further, I hereby release, discharge, and otherwise indemnify Elite Tournaments, Southampton Football Club, their employees, associated personnel, and volunteers, including the owner of fields and facilities utilized for the Programs, against any claim by or on behalf of my player son/daughter as a result of my son's/daughter's participation in the Programs and/or being transported to or from the Programs. I hereby authorize the transportation of my son/daughter to or from the Programs.

My player son/daughter has received a physical examination by a licensed medical doctor and has been found physically capable of participating in the sport of soccer. I have provided written notice, which is submitted in conjunction with this release and attached hereto, setting forth any specific issue, condition, or ailment, in addition to what is specified above, that my child has or that may impact my child's participation in the Programs. I give my consent to have an athletic trainer and/or licensed medical doctor or dentist provide my son/daughter with medical assistance and/or treatment and agree to be financially responsible for the reasonable cost of any such assistance and/or treatment.

This authorization is effective from the _____, (First date of your tour) to _____, (Last date of your tour.)

_____   _____
              Signature of Parent/Guardian   Date