**ST. MARY’S Coed Soccer Medical Release Form**

**Participant Information:**

* **Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Emergency Contact Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Emergency Contact Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Relationship to Participant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Medical Conditions (if any):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Primary Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Physician Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Health Insurance Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Policy Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Release and Indemnification Statement:** I agree to participate in the Adult Co-Ed Soccer Program knowing that safety precautions will be taken but realize that there is an inherent risk involved in participating in recreational activities. I understand that **ST. MARY’S Coed Soccer** is not providing accident or hospitalization insurance for League participants. I do hereby release **ST. MARY’S Coed Soccer**, its officials, and volunteers from accountability for any liabilities, including attorney's fees and court costs, arising from any injuries that might occur during the League-sponsored activities. I also authorize **ST. MARY’S Coed Soccer** to take photographs of me for promotional purposes.

Additionally, I authorize the representatives of **ST. MARY’S Coed Soccer** to provide emergency medical care and treatment as deemed necessary for my well-being. If I am unable to communicate my medical needs, I grant permission for emergency personnel to secure appropriate medical care, including hospitalization, surgery, anesthesia, or any other necessary treatment. I understand that I am responsible for any medical costs incurred as a result of participation in league activities.

With my signature, I confirm that I am 18 or older, that I understand the contents of this release, and that my signature is freely and willingly signed.

**Participant Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_