

# Sporting Club Tallahassee Soccer Academy Medical Release Form 2026-27



I / We \_\_\_\_\_ (parent(s)/guardian(s) name(s))  
hereby give permission for any and all medical attention to be administered to my child  
\_\_\_\_\_ (child/player name) in the event of an accident,  
injury, illness, etc. under the direction of the person(s) listed below until such time as I/we may be  
contacted. I assume the responsibility for the payment of any such treatment. This release is effective  
for the period of one year from the date given below.

**I HAVE READ THIS RELEASE, FULLY UNDERSTAND ITS TERMS, AND THAT I HAVE GIVEN  
SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY  
INDUCEMENT.**

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 2026.

\_\_\_\_\_  
Player Name

\_\_\_\_\_  
Parent(s)/Guardian(s) Signature

\_\_\_\_\_  
Cell/Work Phone

\_\_\_\_\_  
Parent(s)/Guardian(s) Printed Name

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Address (include Street, City & Zip code)

**In the event I cannot be reached, the following persons may act on my behalf as stated above:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship (i.e. Coach)

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship (i.e. Coach)

## **EMERGENCY CONTACT**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Contact Phone

\_\_\_\_\_  
Medical Conditions/Allergies

\_\_\_\_\_  
Primary Medical Insurance Company

\_\_\_\_\_  
Name of the Primary insured/policy holder

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

\_\_\_\_\_  
Address (include Street, City & Zip code)

\_\_\_\_\_  
Insurance Contact Phone #