CHATTANOOGA FC ACADEMY
MEDICAL RELEASE

REV 5/2020

Player (Registrant's) Name _____ M or F (circle) DOB ____/____/____

Full Name of Parent/Legal Guardian completing Waiver _____

Relationship to Player (e.g. father/mother/guardian) _____

Address _____

City _____State_____ Zip_____

Email _____ Phone _____

Name of Emergency Contact (in addition to above)

_____

Phone _____

Consent for Medical Treatment

I, the parent/legal guardian of the above named player, a minor ("Registrant"), request that in my absence, the Registrant be admitted to any hospital or medical facility for diagnosis and treatment. I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x–ray treatment of the Registrant, my dependent. This care may be given under whatever conditions are necessary to preserve the life, limb, or well–being of my dependent. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the Registrant named above.

Signature of Parent/Legal Guardian _____

Signature Date_____/_____/_____

Family Physician _____ Phone _____

Known allergies of this player_____

Any other medical problems? _____