



United Futbol Academy (UFA)

PO Box 1168
Cumming, GA 30028

www.UnitedFA.org
678-648-7033

MEDICAL RELEASE FORM

I, _____ (Parent/Guardian's Name) hereby give permission for any and all medical attention to be administered to my child, _____ (Child's Name) in the event of accident, injury, sickness, etc., under the direction of the people listed below, until such time as I may be contacted. I also 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.

ADDRESS: _____

HOME PHONE: _____

CELL PHONE: _____

INSURANCE COMPANY: _____

POLICY NUMBER: _____

Name of Insured: _____

In case I cannot be reached, any of the following individuals are designated to act on my behalf.

- COACH
- ASSISTANT COACH
- MANAGER
- Any league representative where my child is playing.
- Any tournament representative where my child is participating in a tournament

PHYSICIAN: _____

ADDRESS: _____

PHONE: _____

KNOWN ALLERGIES: _____

SIGNATURE (PARENT/GUARDIAN) _____ DATE _____

Subscribed and Sworn before me,

This _____ day of _____, 20____

Notary Public