TRUMBULL UNITED SOCCER CLUB, INC.
EMERGENCY MEDICAL INFORMATION FORM

MANAGERS – This form MUST be TAKEN TO ALL TEAM ACTIVITIES

_____/___/_____ _____

Participant's full name *Date of Birth* *Parent or Home e-mail (please print clearly)*

_____ _____

Participant's Home Address *City, State & Zip Code* *Participant's Home Phone #*

_____/_____ _____/_____

Parent or Guardian Name (s) *Parent/Guardian cell phone #'s*

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1. WAIVER OF LIABILITY: ***By signing at the bottom of this page, I give my permission for _____ ("the participant") to participate in any and all Trumbull United Soccer Club, Inc. ("TUSC") activities during the current Club year. I assume all risks and hazards incidental to such participation, including transportation to and from activities. I do hereby release, indemnify and hold harmless TUSC and its officials, coaches, referees and representatives from any claim arising out of injury or medical treatment to the participant. I hereby certify that the participant has been examined by a physician and has been determined to be physically fit to participate in all TUSC activities. I also agree that the participant will participate and abide by TUSC and CJSA rules, regulations, policies & procedures and by-laws.***

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2. AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT: By signing at the bottom of this page, I authorize that in the event of an emergency, if I cannot be reached, I want the person named below, to be contacted and that I authorize them to act on my behalf in this regard. If neither I nor my agent (indicated below) can be reached, I acknowledge that the participant's coach(es) or parent(s) who are acting in the capacity of activity supervisors have my consent to authorize emergency medical treatment for the participant.

_____ _____

Full name of emergency contact *Emergency Contact's Phone #(s)*

_____ _____

Address of emergency contact *Relationship of emergency contact to participant*

Does the participant have any illnesses, conditions or physical problems that require special attention? ____ No ____Y
If yes, please explain:_____

List any medications taken by the participant: _____
Date of participant's last tetanus shot: _____

_____ _____

Full name of participant's primary care physician or office name *Physician's Office Phone #*

If a visit to a hospital is necessary, please indicate preferred hospital: _____

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3. INSURANCE INFORMATION: You MUST provide the participant's medical insurance information below.

_____ _____

Name of Insurance Company or "Do Not Have" *Participant's Insurance Identification #*

_____ _____

Name of Insured *Type of Plan (i.e., HMO, PPO, HUSKY, etc.)*

WAIVER OF LIABILITY/AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT:

_____ _____ _____/_____/_____

Print your name *Sign your Name* *Date*

Indicate if you are the Parent ___ or Step-Parent ___ or Legal Guardian ___ of the minor participant