



The Villages Soccer Club  
 703 Buena Vista Blvd.  
 The Villages, FL 32162  
 www.TheVillagesSoccerClub.com  
 info@TheVillagesSC.com  
 (352) 561-8239

Player's Full Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Gender (circle) M or F  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Email(s) \_\_\_\_\_

Medical Problems, Drug Reactions and/or Allergies \_\_\_\_\_

Player's Physician \_\_\_\_\_ Phone \_\_\_\_\_  
 Primary Medical Insurance Company \_\_\_\_\_  
 Policy Holder Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Parent/Guardian Relationship to player \_\_\_\_\_  
 Home/Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Parent/Guardian Relationship to player \_\_\_\_\_  
 Home/Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

In an emergency when parents cannot be reached, please contact:

Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Name \_\_\_\_\_ Phone \_\_\_\_\_

**MEDICAL TREATMENT AUTHORIZATION AND LIABILITY WAIVER**

I hereby give my consent to have an athletic trainer, coach, team manager, emergency medical technician, nurse, medical treatment facility, and/or doctor of medicine or dentistry or associated personnel provide the applicant/participant with medical assistance and/or treatment and agree to be financially responsible for the cost of such assistance and/or treatment. I understand treatment for injury will be based on information provided herein. I hereby authorize emergency transportation of the applicant/participant to a medical treatment facility should an individual listed above consider it to be warranted. I recognize the possibility of physical injury associated with soccer, and hereby release, discharge, and otherwise indemnify The Villages Soccer Club, their sponsors, and its affiliated organizations, and the employees and associated personnel of these organizations, against any claim by or on behalf of the soccer player named above as a result of that player's participation in The Villages Soccer Club programs and/or being transported to or from the same, which transportation I hereby authorize.

This authorization shall remain in effect for 1 (one) calendar year from the date of signing, unless revoked in writing.

Sign \_\_\_\_\_ Date \_\_\_\_\_

Sign \_\_\_\_\_ Date \_\_\_\_\_

Proud member of:

