LAMORINDA SOCCER MEDICAL CONSENT FORM

2010-2011 SEASON

As parent or legal guardian of ____________________________________, I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb, or well being of my dependent.

NAME____DATE__________________________

INSURANCE CARRIER____

POLICY NUMBER____

INSURED 'S NAME____

SIGNATURE____