

LAMORINDA SOCCER MEDICAL CONSENT FORM

2011-2012 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 \_\_\_\_\_