

# JACKSON select

## CONSENT TO MEDICAL TREATMENT

I/we, \_\_\_\_\_, the parent(s) or legal guardian(s)  
of \_\_\_\_\_, do hereby authorize Jackson Select act in our stead and  
place in seeking and obtaining any medical care or treatment of any kind or description, including  
surgical and dental care, which it, or they shall deem to be necessary and appropriate and as if they,  
Jackson Select, or their designee, were said child's legal guardian.

THIS DOCUMENT IS INTENDED TO ALLOW ANY PHYSICIAN, DENTIST, TECHNICIAN, OR  
OTHER MEDICAL PERSONNEL TO TREAT THE ABOVE MINOR IN A MEDICAL SITUATION  
WHEN THEY ARE UNABLE TO OBTAIN OUR IMMEDIATE CONSENT AT THE TIME OF  
TREATMENT.

The undersigned does hereby release Jackson Select, or its designee, from any and all liability  
whatsoever which might arise by reason of said Jackson Select, or its designee, seeking or obtaining  
medical care or treatment for the above named child, and the undersigned does hereby agree to be  
responsible for and to pay hospital, physician, dentist or other medical personnel or facility and shall  
reimburse, indemnify and save Jackson Select, or its designees, fully harmless as to any and all  
expenses of any type, nature or description incurred in obtaining such medical care or treatment.

(Parent or Legal Guardian) \_\_\_\_\_

(Parent or Legal Guardian) \_\_\_\_\_

Date: \_\_\_\_\_

City: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ (PLEASE PRINT CLEARLY!)

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LIST ALL MEDICAL PROBLEMS:

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PERSON TO NOTIFY IN CASE OF EMERGENCY:

NAME: \_\_\_\_\_  
RELATION: \_\_\_\_\_  
PHONE NO: \_\_\_\_\_

DOCTOR TO NOTIFY IN CASE OF EMERGENCY:

NAME: \_\_\_\_\_  
PHONE NO: \_\_\_\_\_

DENTIST TO NOTIFY IN CASE OF EMERGENCY:

NAME: \_\_\_\_\_  
PHONE NO: \_\_\_\_\_

PREFERRED HOSPITAL: \_\_\_\_\_

PLAYERS NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY,STATE,ZIP: \_\_\_\_\_

HOME PHONE : \_\_\_\_\_ SEX: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PARENT(S) or GUARDIAN(S) NAME: \_\_\_\_\_

INSURANCE CARRIER: \_\_\_\_\_

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## LIABILITY RELEASE

I, We understand and agree that soccer is a sporting activity involving physical exertion and competition and like other sporting activity it comes with an inherent risk of injury as a result of participation which cannot be fully eliminated.

The undersigned, individually, and as parent(s) or legal guardian (s) of \_\_\_\_\_ do hereby for ourselves and said minor child, and our respective heirs and personnel representatives, hereby fully release and agree to save harmless Jackson Select, or their designee and any other person acting or serving in the capacity of coach or assistant coach or any other person participating as a player in the affiliated leagues or activities in which the afford said child is a participant from any and all loss, damage, claim for damage or liability which may hereafter be asserted as a result of said minor child's participation in any game, practice session, or other related activity including transportation to and from games or practice sessions or other related events.

Print Name of Parent or Legal Guardian \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Signature)

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## MEDICAL RELEASE FORM

As parent/legal guardian of \_\_\_\_\_, I request that in my absence the above player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the minor above. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above named player.

Player's Date of Birth \_\_\_\_\_ Date of last Tetanus Booster \_\_\_\_\_

Known allergies of this player, including any allergies to medicine:

\_\_\_\_\_

Any other Medical problems should be noted: \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone No: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Person responsible for Charges: \_\_\_\_\_

Address: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Fax) \_\_\_\_\_

Person to notify if parent or guardian is unavailable: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy No: \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

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STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

Sworn to and subscribed before me on the \_\_\_ day of \_\_\_\_\_, 20\_\_ Notary  
Public in and for the State of \_\_\_\_\_

Commission Expires \_\_\_\_\_