



MAGIC CITY SOCCER CLUB
BENCH PERSONNEL REGISTRATION & MEDICAL RELEASE FORM

Please print clearly and legibly in ink and fill out completely:

FIRST NAME _____ LAST NAME _____ BIRTHDATE _____

[] MALE [] FEMALE

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

Is your tetanus booster current? [] Yes [] No

Known allergies _____

Any other notable medical problems _____

Family physician _____ Phone _____ Preferred hospital _____

Insurance company _____ Policy number _____ Name of insured _____

MEDICAL RELEASE

I, _____, request that I 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 and nurses, to perform any diagnostic procedures, treatment procedures, operative procedures, and x-ray procedures on the above-named person. I have not been given a guarantee as to the results of the examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named person.

Signed _____ Date _____