



**USSA Western Region  
2011-2012 Medical Release**

Athlete Name \_\_\_\_\_ Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Birth Date \_\_\_\_\_

E Mail \_\_\_\_\_ Cell Phone \_\_\_\_\_

Parent \_\_\_\_\_ Parent \_\_\_\_\_

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

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

Work Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

E Mail \_\_\_\_\_ E Mail \_\_\_\_\_

**Insurance Coverage**

Company \_\_\_\_\_ Identification # \_\_\_\_\_

Policy Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

**Medical History**

Allergies \_\_\_\_\_

Medication \_\_\_\_\_

Baseline Concussion Information \_\_\_\_\_

Other Medical Information \_\_\_\_\_

**Foreign Coverage** (for athletes traveling outside the U.S.) We have verified with our insurance company that this policy is effective for care in foreign countries. Any additional information necessary is attached to this form. Our son/daughter will travel with a means of payment for medical services (e.g. credit card).

**Athlete Medical Release**

Athlete or Parent, if Athlete is under the age of 18 years, hereby authorizes USSA/Western Region Staff to secure hospital, medical, surgical and dental care or treatment and/or procedures for the above named athlete. Parent also consents that in the event of injury to the athlete; coaches can authorize that athlete to receive care, treatment and/or procedures, under the instructions and directions of the licensed physicians on call at the emergency room of the nearest hospital or emergency facility. USSA/Western Region shall notify Parent at the earliest possible time before, during or after such care, treatment and/or procedures are authorized. Parent knowingly and voluntarily consents in advance to such care, treatment and or procedures to encourage the physicians and USSA/Western Region to exercise their best judgment as to the requirements of such care, treatment and/or procedures. Parent specifically holds harmless and indemnifies USSA of and from any and all costs and/or claims of any nature arising out of the provision of such care, treatment and/or procedure.

Athlete Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

*Please send to: USSA Western Region, USSA, PO Box 100, 1 Victory Lane, Park City UT 84060 Fax: 435.940.2810*