MEDICAL INFORMATION DECLARATION, HOLD HARMLESS AGREEMENT, AND LIMITED POWER OF ATTORNEY FOR HEALTH CARE

Alliance Cincinnati

PLAYER'S NAME			AGE	BIRTHDATE
STREET ADDRESS		CITY	STATE	ZIP CODE
FATHER'S DAYTIME PHONE	HOME PHONE	E-MAIL ADDRESS		
MOTHER'S DAYTIME PHONE	HOME PHONE	E-MAIL ADDRESS		
EMERGENCY CONTACT NAME	ADDRESS		PHONE	

PLEASE LIST ANY EXISTING MEDICAL CONDITIONS, ALLERGIES, PHYSICAL DISABILITIES OR OTHER CONDITIONS WHICH MAY AFFECT PLAYING SOCCER		
INSURANCE COMPANY NAME	POLICY NUMBER OR CERTIFICATE NUMBER (ATTACH COPY OF BOTH SIDES OF ID CARD)	
DOCTOR'S NAME	ADDRESS	TELEPHONE NUMBER

CERTIFICATION, HOLD HARMLESS AGREEMENT AND LIMITED POWER OF ATTORNEY FOR HEALTH CARE In consideration of my child being permitted to participate in the activities of Cincinnati Soccer Alliance,

I ____ (Parent/Guardian's Name) certify that the information provided above is true and accurate to the best of my knowledge, and agree that any information not provided above will be provided within 10 days of the date shown below.

I further certify that I understand that participating in soccer and the training and activities related thereto as in any other sport entails certain risks, including injury, disease, and/or death and I agree to fully indemnify and hold harmless Cincinnati Soccer Alliance, its coaches, managers, trainers, assistants, agents, servants, heirs, executors, employees, administrators and assigns, and all other persons, firms, and corporations from any and all claims, demands, causes of action, of any kind or nature, which may arise, directly or indirectly, as a result of my child's participation in the activities of the team and/or the transportation of my child to or from such activities.

In the event that I am not present at the time of any injury, illness, or accident which shall involve my child, I hereby authorize and direct the team coach, or any other such person as he or she may direct, to obtain any and all necessary emergency medical treatment, services, and medication, including but not limited to emergency transportation, treatment, medication, surgery, or any other means necessary to protect the life and health of my child as named herein, and grant to them my power of attorney to secure such treatment and to execute such documents as shall be necessary, in their sole discretion, to protect and preserve the life, health, and safety of my child. This limited power of attorney shall not expire until I or the emergency contact listed herein can be contacted and can make such decisions, at which time the authority granted by this document shall expire and further shall be effective for one year from the date last entered hereon.

I further agree that I shall be financially responsible for all costs associated with medical treatment received as a result of the authority granted herein.

IN WITNESS WHEREOF, I have hereunto set my hand at ____________________________, Ohio this __________ day of ______________________, 20___ .

Signature of Parent or Legal Guardian ____ Sworn to

before me and subscribed in my presence this _______ day of _____________________ , 20___ .

____ Notary Public, State of Ohio