



Permission to Participate & Medical Authorization

ESAD Soccer Academy HOT SHOT PROGRAM

Athletes NAME: _____ **Mailing Address:** _____

Gender: M / F **City:** _____

Date of Birth: ___ / ___ / ___ **State:** _____ **Zip:** _____

Home Phone: _____ **E-Mail Address:** _____

MEDICAL RELEASE:

Medical Conditions

1. **List allergies, medications, illnesses, injuries, (etc) :**

2. **In case of emergency notify:** _____

3. **Relationship to athlete:** _____

4. **Home Phone:** _____ **Other Phone:** _____

The above named athlete has my permission to participate in the FC Napoli Hot Shots program from April 17th through June 30th. I further certify that he/she is capable of participating in a strenuous physical activity, to wit soccer. I also agree to hold harmless the ESAD Soccer Academy and Clinics, its staff, agents, the Preparatory School of Marianopolis, and employees from any and all injuries which may be sustained by the athlete during his/her participating in the program.

In case of emergency, I understand every attempt will be made to contact the person(s) listed above. If contact is unsuccessful, I give my permission to the tending physician to render medical treatment to the participant, including (if necessary) hospitalization. Any expense arising from or illness is the responsibility of the person signing below.

Insurance Company: _____ **Policy Number:** _____

Parent Guardian Signature: _____ **Date:** _____