423 N. Eastern Ave, Las Vegas, NV 89101

MEDICAL RELEASE

Player Name: _____ Date of Birth: _____ Age: ____ Gender: ____

Medical History

(Check all that apply)

- ☐ Asthma
- ☐ Seizure Disorder
- ☐ Heart Condition
- ☐ Allergies to Medication
- ☐ Allergies to Food
- ☐ Previous Concussion(s)
- ☐ ADHD / Behavioral Conditions
- ☐ Diabetes
- ☐ Joint Problems / Past Fractures
- ☐ Sickle Cell Trait
- ☐ Heat-related sensitivity
- ☐ Other: _____

Allergies & Medical Notes

Food Allergies: _____

Medication Allergies: _____

Other Allergies: _____

Additional Medical Concerns: _____

Medications Taken Daily: _____

Insurance Information

Insurance Provider: _____ Policy Number: _____

Subscriber Name: _____

Primary Physician

Physician Name: _____

Phone: _____

Authorization for Medical Care

I/We authorize FC Vegas Academy staff to:

- Render first aid
- Provide CPR/AED assistance
- Contact EMS and permit transport
- Share medical information with medical personnel

I/We understand FC Vegas Academy staff are not medical professionals.

Signature of Parent/Guardian: _____ **Date:** _____