Medical Release Waiver
Date: 04/02/2024
Policy: PSF0009

I understand that participation in athletic activities, including soccer, carries inherent risks of injury, including serious and potentially life-threatening injuries, such as paralysis or death.

Insurance Coverage:

I acknowledge that my registration fees for the Pike Fury FC SCCL program include coverage under a basic accident medical insurance policy provided by US Soccer. This policy is intended to help with unexpected medical costs associated with injuries sustained during program activities.

However, this insurance policy may not cover all medical expenses. I understand that I am responsible for any remaining medical costs not covered by the insurance policy.

Release of Liability:

In consideration of being allowed to participate in the Pike Fury FC SCCL program, I, on behalf of myself, my heirs, executors, and assigns, hereby waive, release, and forever discharge Pike Fury FC SCCL, its officers, directors, employees, agents, volunteers, and successors in interest (collectively, the "Releasees") from any and all claims, demands, losses, or liabilities arising out of or in any way connected with my participation in the Program, including, but not limited to, any injuries sustained during program activities.

Medical Information Disclosure:

I certify that I am in good health and physically fit to participate in the Pike Fury FC SCCL program. I further certify that I have disclosed any and all medical conditions, allergies, or limitations that may affect my ability to participate safely in the program.

Assumption of Risk:

I voluntarily assume all risks associated with participation in the Pike Fury FC SCCL program, including the risk of injury.

Medical Treatment Authorization:

In the event of an emergency, I authorize Pike Fury FC SCCL staff to seek necessary medical treatment for me. I understand that I am financially responsible for the cost of any medical treatment received.

Medical Insurance Information:

Please provide the following information about your primary medical insurance:

- **Insurance Carrier:** [Insurance Carrier Name]
- **Policyholder Name:** [Policyholder Name]
- **Policy Number:** [Policy Number]
- **Phone Number:** [Phone Number]

Required Signatures:

Player Signature: _______________________________ (Participant 18 years or older)

OR

Parent/Guardian Signature: _______________________________ (Participant under 18 years old)

Printed Name: _______________________________

Date: _______________________________