



*Suburban Optimist Club Youth Group  
Suburban Optimist Club of Buena Park*

Medical Release and Consent for Medical Treatment

I, the parent or guardian of the below named player, hereby registers him or her to participate in all activities as a member of the Suburban Optimist Club Youth Group (SOCYG), and do hereby release SOCYG, its officers, members, coaches, and any other person(s) connected with the sports league or programs in which SOCYG participates, from any and all liability for any injury or loss sustained by the player while playing, practicing, traveling and participating in such events. The signing of this parent and player agreement shall be considered a waiver and releases SOCYG from all responsibilities for injuries of any nature incurred while participating in any SOCYG activity(s) program.

I understand and accept the risks inherent in basketball and other athletic activities. I/we understand that medical insurance is my/our own responsibility. .

I/We as agent(s) for the undersigned, consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority to power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care, which a physician meeting the requirements of this authorization , may, in the exercise of his/her best judgment, deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

Child's Name:		DOB:
Fathers Name:	Home Phone:	Cell Phone:
Mothers Name:	Home Phone:	Cell Phone:
Contact Person: (Relationship)	Home Phone:	Cell Phone:
Doctor:	Phone:	
Insurance:	Policy #:	
Medical Conditions/Allergies:		

\_\_\_\_\_  
Player Signature Date

\_\_\_\_\_  
Parent Signature Date