

Release Authorization for EMERGENCY TREATMENT

I understand that I am required to maintain and carry accident medical insurance coverage for the child listed on this application and I verify the coverage information attached herewith is accurate and true.

In the case of an emergency and if I cannot be reached, I authorize the staff member of the USF Department of Intercollegiate Athletics to obtain whatever medical treatment he/she deems necessary for the welfare of my child listed on this application. I further understand that I will be financially responsible for all charges and fees incurred in the rendering of said emergency treatment, regardless of whether or not my medical insurance would cover such charges and fees.

I am the parent/ guardian of the minor _____ and I am signing this Release on behalf of the said minor

Signature of Parent/ Guardian of Minor

Date

Please return both pages to

USF Women's Soccer Camps
2130 Fulton St
San Francisco, CA 94117-1080