

MEDICAL RELEASE FORM

As the parent/legal guardian of _____, I request that in my absence the above-named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

Date of Players Birth ____ / ____ / ____ Date of last Tetanus Booster ____ / ____ / ____
Month Day Year Month Day Year

Known allergies of this player, including any allergies to medicine _____

Any other medical problems which should be noted _____

Family Physician _____ Phone (____) _____ - _____

Name of Parent/Guardian _____

Address _____

City/State/Zip _____

Phone _____ H _____ W _____ FAX _____

Person responsible for charges (if different from above) _____

Address _____

City/State/Zip _____

Phone _____ H _____ W _____ FAX _____

Person to notify if parent/guardian is unavailable _____

Phone _____ H _____ W _____ FAX _____

Insurance Carrier _____ Policy Number _____

Signature Of Parent/Guardian _____

JURAT

STATE OF _____ §

§

COUNTY OF _____ §

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Sworn to and subscribed before me on the ____ day of _____, 20____

Notary Public in and for the State of _____

Commission expires _____

MEDICAL RELEASE FORM

I hereby give permission for any and all medical attention necessary to be administered to my child _____ in the event of an accident, injury, sickness, etc. under the direction of the person(s) listed below, until such time as I may be contacted. This release is effective until revoked by me. I also hereby assume the responsibility for payment of such treatment.

ADDRESS: _____

HOME PHONE: _____ WORK: _____

INSURANCE COMPANY: _____

POLICY NUMBER: _____

In case I cannot be reached, either of the following is designated:

COACH: _____ PHONE: _____

ASST. COACH: _____ PHONE: _____

MANAGERS: _____ PHONE: _____

PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

KNOWN ALLERGIES: _____

SIGNED: (parent) _____

SUBSCRIBED AND SWORN TO BEFORE THIS _____ DAY OF _____

NOTARY PUBLIC _____

