



MEDICAL RELEASE FORM

As the parent/guardian of _____, I request that in my absence the above 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.

Birth Date of Player ___/___/___ Date of last Tetanus Booster ___/___/___

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

Any other medical problems which should be noted _____

Family Physician _____ Phone # _____
Insurance Carrier _____ Policy Number _____

Name of Parent/Guardian _____
Address _____
City/State/Zip _____
Home Phone _____ Work Phone _____ FAX _____

Person responsible for charges (if different than above) _____
Address _____
City/State/Zip _____
Home Phone _____ Work Phone _____ FAX _____

Person to notify if parent/guardian is unavailable _____
Home Phone _____ Work Phone _____ FAX _____
Signature of Parent/Guardian _____

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

Notary Public _____

My Commission expires _____