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 procedure, 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.

Date of Players Birth ______/_____/________
Month Day Year

Date of last Tetanus Booster: __________/________/_____________
Month Day Year

Known allergies of this player, including any allergies to medicine and ANY medical problems should be noted here: ____
____
____

Family Physician: ____________________ Phone (____) _________ - _______

Name of Parent or Legal Guardian : _____________________________________

Address: ____

City: ______________________________ State: ______________ Zip: ______

Cell Phone: _______________ Home Phone: _______________

Person responsible for charges (if different from above): _________________________

Address: ____

City: ______________________________ State: ______________ Zip: ______

Cell Phone: _______________ Home Phone: _______________

Emergency Contact Name: ____________________ Phone: (___) ____-_____

Insurance Carrier: ________________________ Policy Number: ____________

Signature of Parent/Guardian: ____________________________ Date: _______