



MEDICAL RELEASE FORM

As the parent/legal 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, 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 player. 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.

Player's Birth Date: _____

Date of Last Tetanus Booster: _____

Known allergies of player, including any allergies to medicine:

Any other medical problems that should be noted:

Family Physician: _____ Phone #: _____

Insurance Carrier: _____ Policy #: _____

Name of Parent/Legal Guardian: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Person Responsible for Charges (If Different From Above): _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Person to Notify if Parent/Legal Guardian is Unavailable: _____

Home Phone: _____ Work Phone: _____

Parent/Legal Guardian's Signature

Date