

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 and 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 _____ / _____ / _____
Month Day Year

Date of last Tetanus Booster _____ / _____ / _____
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