

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 technician 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.

Player's Date of Birth _____ / _____ / _____

Date of Last Tetanus Booster _____ / _____ / _____

Known allergies, including any allergies to medicine _____

Any other medical problems which should be noted _____

Family Physician _____ Phone (____) _____

Name of Parent/ Guardian _____

Address _____

Phone C (____) _____ H (____) _____ W (____) _____

Person responsible for charges (if different from above) _____

Address _____

Phone C (____) _____ H (____) _____ W (____) _____

If Parent/Guardian unavailable, please contact:

Name _____

Phone C (____) _____ H (____) _____ W (____) _____

Insurance Carrier Name _____ Policy Number _____

Printed Name of Parent/ Guardian

Signature of Parent/ Guardian

Date