

Medical Release Form

I, _____ (Parent/Guardian's Name) hereby give permission for any and all medical attention to be administered to my child (Child's Name) _____ in the event of an accident, injury, sickness etc., under the direction of the person(s) listed below, until such a time as I may be contacted. I also assume the responsibility for the payment of such treatment. This release is effective for the period of one year from the date given below.

Player's Name:		
Street Address:		
City:	State:	Zip Code:
Mother/Guardian Name:		
Last:	First:	
Home Phone:	Cell Phone:	Work Phone:
Father/Guardian Name:		
Last:	First:	
Home Phone:	Cell Phone:	Work Phone:

Insurance Co: _____ Policy Number: _____

In case I cannot be reached, any of the following persons is designated to act on my behalf:

Coach: _____

Assistant Coach: _____

Team Manager: _____

Trainer: _____

League representative where my child is participating in a tournament: Yes or No

Physician: _____

Address: _____

Phone: _____

Known Allergies/Medical Conditions: _____

Other Medical Conditions: _____

Signature of Parent/Guardian: _____ Date: _____