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 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)_____(Cell)_____

Person responsible for charges (if different from above)
_____
Address_____City /State/Zip_____
Phone (H)_____(W)_____(Cell)_____

Person to notify if parent/guardian is unavailable_____
Phone (H)_____(W)_____(C)_____

Insurance carrier_____ Policy Number _____
Signature of Parent/Guardian _____