



MEDICAL RELEASE FORM



PLAYER NAME _____

As the parent or guardian of the above named minor player, I request that in my absence the above player be transported and 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 the examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above named player. I also, agree to be financially responsible for the costs incurred for such medical or dental care.

Birth Date of Player ____/____/____ Date of last Tetanus Booster ____/____/____

Known allergies of this player, including any allergies to medicine _____

Any other medical problems which should be noted _____

Family Physician _____ Phone # _____

Insurance Carrier _____ Policy Number _____

Name of Parent/Guardian _____

Address _____

City/State/Zip _____

Home Phone _____ Work Phone _____ FAX _____

Person responsible for charges (if different than above) _____

Address _____

City/State/Zip _____

Home Phone _____ Work Phone _____ FAX _____

Person to notify if parent/guardian is unavailable _____

Home Phone _____ Work Phone _____ FAX _____

Signature of Parent/Guardian _____ DATE _____