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 Player's 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

_____

Name of Parent/Guardian _____

Address _____ City/State/Zip_____

Phone-H_____ C _____W _____

Person responsible for charges (if different from above)_____

Address _____ City/State/Zip_____

Phone-H_____ C _____W _____

Person to notify if parent/guardian is unavailable_____

Phone-H_____ C _____W _____

Family Physician_____ **Phone ( )**_____

Insurance Carrier_____ **Policy Number**_____

Signature of Parent/Guardian_____