2018 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.

Birth Date of Player _____ Date of last Tetanus Booster _____

Known allergies of this player, including allergies to medicines _____

_____

Any other medical problems that should be noted _____

_____

Family Physician _____ Phone Number _____

Name of Parent/Guardian _____
(Please print)

Address _____

City, State, ZIP _____

Home Phone _____ Work _____ Cell _____

Person responsible for charges (if different from above) _____

Address _____

City, State, ZIP _____

Home Phone _____ Work _____ Cell _____

Person to notify if parent /guardian is unavailable _____

Address _____

City, State, ZIP _____

Home Phone _____ Work _____ Cell _____

Insurance Carrier _____ Policy No. _____

Signature of Parent/Guardian *X* _____ Date _____