

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:

Family Physician		Phone	
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Parent/Guardian		Home Phone	
		Work/Cell Phone	

Parent/Guardian Address		City, State Zip	
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Person responsible for charges, if differs		Home Phone	
		Work/Cell Phone	

Person responsible for charges address		City, State Zip	
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Person to notify if parent/guardian unavailable		Home Phone	
		Work/Cell Phone	

Insurance Carrier		Policy Number	
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Signature of parent/guardian _____

NOTARIZATION

State of _____ County of _____

Sworn to and subscribed before me on the _____ day of _____, 20_____.

Notary public in and for the State of _____ My commission expires _____