

MEDICAL RELEASE FORM

As the parent/legal guardian of:

Name of Player: _____

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: _____ Date of last Tetanus Booster: _____

Know allergies of this player, including any allergies to medicine: _____

Any other medical problems which should be noted: _____

Family Physician: _____ Phone: (____) _____

Parent/Guardian: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone # H: (____) _____ Work #: (____) _____

Person responsible

for charges:

(if different from above) _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone # H: (____) _____ Work #: (____) _____

Person to notify if

parent/guardian is

unavailable: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone # H: (____) _____ Work #: (____) _____

Insurance Carrier: _____ Policy Number: _____

Name of Insured: _____ Phone: (____) _____

Name of Parent / Guardian: _____

Signature of Parent /Guardian: _____

Date: _____ **Witness:** _____