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**	
Parent/Guardian		**Home Phone**	
		Work/Cell Phone	
Parent/Guardian Address		**City, State Zip**	
Person responsible for charges, if differs		**Home Phone**	
		Work/Cell Phone	
Person responsible for charges address		**City, State Zip**	
Person to notify if parent/guardian unavailable		**Home Phone**	
		Work/Cell Phone	
Insurance Carrier		**Policy Number**	

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** _______________________