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 Players 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 (____)____________________

Name of Parent/Guardian____

Address____

City/State/Zip____

Phone H(____)_______________ W(____)______________FAX (___)______________

Person responsible for charges (if different from above)___________________________

Address____

City/State/Zip____

Phone H(___)________________ W(___)______________ FAX (___)______________

Person to notify if parent/guardian is unavailable________________________________

Phone H(___)________________ W(___)______________ FAX (___)______________

Insurance Carrier_____________________________ Policy Number_________________

Signature of Parent/Guardian____