



MEDICAL RELEASE FORM

I HEREBY GIVE MY PERMISSION FOR ANY AND ALL MEDICAL ATTENTION NECESSARY TO BE ADMINISTERED TO MY CHILD,
(Name) _____

IN THE EVENT OF AN ACCIDENT, INJURY, SICKNESS, ETC., UNDER THE DIRECTION OF THE PERSON LISTED BELOW, UNTIL SUCH TIME AS I MAY BE CONTACTED. I ALSO HEREBY ASSUME THE RESPONSIBILITY FOR PAYMENT OF SUCH TREATMENT.

PARENT/GUARDIAN NAME _____
ADDRESS _____
TELEPHONE (HOME) _____
TELEPHONE (CELL) _____
INSURANCE CO. _____
POLICY NUMBER _____

IN THE EVENT I CANNOT BE REACHED, THE FOLLOWING PERSON(S) ARE SO DESIGNATED:

NAME OF PERSON _____
RELATIONSHIP TO PLAYER _____
ADDRESS _____
TELEPHONE (HOME) _____
TELEPHONE (CELL) _____

FAMILY/PLAYER PHYSICIAN _____
ADDRESS _____
TELEPHONE _____

ANY KNOWN ALLERGIES _____

OTHER INFORMATION _____

PARENT/GUARDIAN SIGNATURE _____

DATE _____