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** ____________

Policy-holder's Name ____________ **Group Number** ____________

Carrier's Phone Number ____________

Signature of parent/guardian ____________________ **Date** ____________________