



Medical Release Form

As the parent/legal guardian of _____ I request that in my absence the above-named minor 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 license technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures, and an x-ray treatment of the above-named 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 minor. I accept full financial responsibility for any such treatment. I also give permission for any transportation required to a medical facility and assume full financial responsibility for said transportation.

Player's Date of Birth: _____ Date of last Tetanus Booster: _____

Known allergies of this player, including allergies to medicines: _____

Other medical problems or activity restrictions: _____

Primary Care Physician _____ Phone: _____

Name of Parents/Legal Guardians: _____

Address: _____

Town _____ State _____ Zip _____

Home Phone: _____

Father's Cell Phone: _____ Mother's Cell Phone: _____

Person to contact if Parent/Guardian is not available: _____

Telephone: _____

Person responsible for charges (if different than above): _____

Address: _____

Town _____ State _____ Zip _____

Telephone: _____

Insurance Carrier: _____ Subscriber: _____

Medical Insurance Policy Number: _____

Signature of Parent/Guardian: _____ Date: _____