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, duty 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.

Players Date of Birth ____/___/_____ Date of last Tetanus Booster___/___/____
Month Day Year Month Day Year

Known Allergies of this player, including any allergies to medications: _____
_____

Any other medical problems which should be noted: _____
_____

_____

Family Physician: _____ Phone: (_____)_____

Name of Parent/Guardian_____

Address:_____City/State/Zip_____

Phone (H)_____ (W)_____ (F)_____

Person to notify if parent/guardian is unavailable_____

Phone (H)_____ (W)_____ (F)_____

Insurance Carrier _____Policy Number_____

Signature of Parent/Guardian_____ Date_____

STATE OF _____ JURAT

COUNTY OF _____

Sworn to and subscribed before me on the _____day of _____, 20___.

_____
Notary Signature
Notary Public in and for the State of _____

My commission Expires: _____