MEDICAL RELEASE FORM

As the parent/legal guardian of ___________________________________, I request that in the event of injury to my child 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 Doctor of Medicine or Doctor 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 necessary for the treatment of my child's injury. I understand that there are no guarantees as to the results of examination or treatment.

Date of Birth: ______ /______ /_________
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: _______________________________________ Date: _______________

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