

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: _____ Date of Last Tetanus Booster: _____

Known allergies of this player, including any allergies to medicine: _____

Any other medical problems which should be noted: _____

Family Physician: _____ Telephone: _____

Name of Parent/Guardian: _____

Address: _____

City/State/Zip: _____

Phone: cell _____ home _____ work _____

Person to notify if parent/guardian is not available: _____

Phone: cell _____ home _____ work _____

Insurance Carrier: _____

Policy Nos.: Group No. _____, ID No. _____

Person Responsible for Charges (if different than above): _____

Address: _____

City/State/Zip: _____

Phone: cell _____ home _____ work _____

Signature of Parent/Guardian: _____

Date: _____

