MEDICAL RELEASE FORM

As the parent/guardian of _____, I request that in my absence the above 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 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.

Birth Date of Player_____/_____/_____ Date of last Tetanus Booster_____/_____/_____

Known allergies of this player, including allergies to medicine_____

_____

Any other medical problems which should be noted_____

_____

Family Physician_____ Phone #_____

Insurance Carrier_____ Policy Number_____

Name of Parent/Guardian_____

Address_____

City/State/Zip_____

Home Phone_____ Work Phone_____ FAX_____

Person responsible for charges (if different than above)_____

Address_____

City/State/Zip_____

Home Phone_____ Work Phone_____ FAX_____

Person to notify if parent/guardian is unavailable_____

Home Phone_____ Work Phone_____ FAX_____

Signature of Parent/Guardian: