

MEDICAL RELEASE FORM

As the parent/legal guardian of _____, I request that in my absence the above-named player be admitted to any hospital 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.

Player's birthdate: ___/___/___ Date of last Tetanus booster ___/___/___

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

Any other medical problems that should be noted: _____

Family Physician _____ Phone _____

Name of parent/guardian _____

Address _____ City/St/Zip _____

Phone _____ (home) _____ (work) _____ (cell)

Person responsible for charge (if different from above): _____

Address _____ City/St/Zip _____

Phone _____ (home) _____ (work) _____ (cell)

Emergency Contact _____

Phone _____ (home) _____ (work) _____ (cell)

Signature of Parent or Guardian _____

JURAT

STATE OF _____

COUNTY OF _____

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

Notary Public in and for State of _____

Commission Expires _____