

# MEDICAL RELEASE FORM

PLEASE PRINT ALL INFORMATION EXCEPT SIGNATURE

I, \_\_\_\_\_  
PARENT/GAURDIAN'S NAME hereby give permission for any and all medical attention to be administered to my child \_\_\_\_\_  
CHILD'S NAME in the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

INSURANCE COMP: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_

In case I cannot be reached, any of the following persons is designated to act on my behalf:

- COACH: \_\_\_\_\_
- ASST. COACH: \_\_\_\_\_
- TEAM MANAGER: \_\_\_\_\_
- A league representative where my child is playing.
- Any tournament representative where my child is participating in a tournament

PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

KNOWN ALLERGIES: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE (PARENT/GUARDIAN) \_\_\_\_\_ DATE \_\_\_\_\_

Subscribed and sworn before me,  
this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Notary Public