

B.O.S.S. Baseball Academy, Inc.



Medical Release

Note: To be carried by Team Manager together with team roster and or eligibility affidavit.

Player: _____ Date of Birth: _____

B.O.S.S. Team: _____ Manager: _____

Parent or Guardian Authorization:

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel. (i.e. EMT, First Responder, E.R. Physician).

Family Physician: _____ Phone: _____

Address: _____

Hospital Preference: _____

In case of emergency contact:

Name Phone Relationship to Player

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Please list any allergies/medical problems, including those requiring maintenance medication. (i.e. Diabetic, Asthma, Seizure Disorder)

Medical Diagnosis	Medication	Dosage and Frequency

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Date of last Tetanus Toxoid Booster: _____

Mr./Mrs./Ms. Authorized Parent/Guardian Signature: _____

WARNING: Protective equipment cannot prevent all injuries a player might receive while participating in Baseball.

