



Kensico Baseball

P.O. Box 11
Valhalla, NY 10595

Medical Release

Player:	
Date of Birth:	

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

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

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

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: _____

Parent/Guardian Name:	
Parent/Guardian Signature:	