

**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 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.

Birth Date of Player \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last Tetanus Booster \_\_\_\_/\_\_\_\_/\_\_\_\_

Known allergies of this player, including any 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 \_\_\_\_\_