MEDICAL RELEASE FORM

As the parent/legal guardian of _____, I request that in my absence the above-named minor 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 minor.

Date of Birth_____/_____/_____
Month Day Year

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

_____

Any other medical problems which should be noted: _____

_____

Family Physician: _____ Phone (____) _____

Name of Parent/Guardian: _____

Address_____

City/State/Zip_____

Phone H(____)_____ W(____)_____FAX (___)_____

Person responsible for charges (if different from above)_____

Address_____

City/State/Zip_____

Phone H(___)_____ W(___)_____ FAX (___)_____

Person to notify if parent/guardian is unavailable_____

Phone H(___)_____ W(___)_____ FAX (___)_____

Insurance Carrier_____ Policy Number_____

Signature of Parent/Guardian_____