MEDICAL RELEASE INFORMATION AND AUTHORIZATION FOR TREATMENT

League ID# 4-05-37-10

Player: _____ Date of Birth:_____

Family Physician_____ Phone:_____

Address:_____

Hospital Preference:_____

In case of emergency contact:

_____

Name Phone Relationship to Player

_____

Name Phone Relationship to Player

Medical Insurance:_____

Company Name/Plan ID/Telephone/Name of Insured

Please list any allergies/medical problems, including those requiring maintenance medication (i.e., Diabetes, Asthma, Seizure Disorder). The purpose of the below 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 booster: _____

AUTHORIZATION FOR TREATMENT – In case of emergency, if the physician(s) listed above cannot be reached, I/we hereby authorize the player(s) listed above to be treated by another licensed, qualified medical professional who is available.

Signature of Parent(s) or Guardian(s) X _____ X _____ Date ____/____/____

WAIVER AND RELEASE – I/We know that the participation in baseball may result in serious injuries and protective equipment does not prevent all injuries to players. I/We do hereby waive, release, absolve, indemnify and agree to hold harmless Del Rey American Little League, Little League Baseball, Inc., the organizers, sponsors, participants and persons transporting my/our child to and from activities from any claim arising out of any injury to my/our child whether the result of negligence or for any other cause, except to the extent in the amount covered by accident or liability insurance. I/we understand that the insurance carried by Del Rey American Little League covers only the amount that is not paid by my/our carrier.

Signature of Parent(s) or Guardian(s) X _____ X _____ Date ____/____/____