# MEDICAL RELEASE FORM

As the parent/legal guardian of _____, I request that in my absence the above named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorized 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, operated procedures and x-ray treatment of the above minor. I have not been given a guaranteed as to the results of the examination or treatment. I authorized a hospital or medical facility to dispose of any specimen or tissue taken from the above named player.

Date of players birth (MM/DD/YY) ____/____/____

Date at last tetanus booster (MM/DD/YY)___/___/___

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 _____

Home Phone _____ Alternate Phone _____

Person responsible for charges (if different from above) _____

Address _____

Home Phone _____ Alternate Phone _____

Insurance Carrier _____ Policy Number _____

Signature of Parent/Guardian _____