

**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 authorize physicians, dentists, staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians, nurses, to perform diagnostic procedures, operative procedures, and x-ray treatment of the above-named minor. I have not been given a guarantee as to the results of the examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above player.

Player's date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last tetanus booster: \_\_\_\_/\_\_\_\_/\_\_\_\_

Known allergies \_\_\_\_\_

Other medical problems which should be noted: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

City, state, and zip code: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Telephone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Name of person responsible for charges (If different than above): \_\_\_\_\_

Address: \_\_\_\_\_

City, state, and zip code: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Telephone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Name of person to notify if Parent/Guardian is unavailable: \_\_\_\_\_

Address: \_\_\_\_\_

City, state, and zip code: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Telephone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

JURAT

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Sworn to and subscribed before me on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Notary Public in and for the State of \_\_\_\_\_

My Commission Expires \_\_\_\_\_

NOTE: This form does NOT require notarization, but MUST be signed by the player's parent or legal guardian.