Print Form

MEDICAL RELEASE FORM
2019-2020

As the parent of: Name of Player:

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, 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.

Date of players birth: _____ Date of last Tetanus Booster: _____

Allergies: _____

Other Medical Conditions: _____

Player's Physician: _____ Phone #: ( )

Name of Parent/Guardian: _____

Street Address: _____ City: _____ State: _____

Zip: _____ Phone # H: ( ) _____ Work #: ( ) _____ Cell #: ( ) _____

Person responsible for charges (if different from above) _____

Street Address: _____ City: _____ State: _____

Zip: _____ Phone # H: ( ) _____ Work #: ( ) _____ Cell #: ( ) _____

Person to notify if parent/guardian is unavailable: _____

Street Address: _____ City: _____ State: _____

Zip: _____ Phone # H: ( ) _____ Work #: ( ) _____ Cell #: ( ) _____

_____ ( )

Medical and/or Hospital Insurance Co Phone #:

_____

Policy Holder Policy Number

Signature of Parent /Guardian: _____ Date: _____

Sworn to and subscribed before me on the _____ day of _____, Yr_____

Notary Public _____

My Commission expires _____