

**REQUIRED FOR ALL GBCYFL PARTICIPANTS**



**GREATER BULLITT COUNTY YOUTH FOOTBALL LEAGUE, INC.**

**MEDICAL RELEASE FORM**

Athlete's Name \_\_\_\_\_ Team \_\_\_\_\_

Parent/Legal Guardian Name: \_\_\_\_\_

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

Phone Number- \*If No Home Number- Leave Blank

Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_ Other: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

<u>Child's Name &amp; Team:</u> *Only One Child Per Form	List all known <u>Allergies</u> - Drug and Food- List all known <u>Medical Conditions</u> - List previous pertinent <u>Surgeries</u> - List all <u>Medications</u> - Prescription & Over the Counter- Taken Regularly

**IN CASE OF EMERGENCY, PLEASE CONTACT (other than parent):**

Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

Does this person have permission to consent for hospital transport? \_\_\_\_\_

Secondary Emergency Contact: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

Does this person have permission to consent for hospital transport? \_\_\_\_\_

---

Primary Care Provider: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_

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

Phone: \_\_\_\_\_

\* In the event my child must be taken to the hospital and a parent/guardian is not present, I give permission for a GBCYFL league/team representative to accompany my child.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_