Medical Release Form

Player: _____ Date of Birth:_____

Parent or Guardian Authorization:

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel. (I.e. EMT, First Responder, E.R. Physician)

Family Physician: _____ Phone: _____

Address: _____

Hospital Preference: _____

In case of emergency contact:

_____

Name Phone Relationship to Player

_____

Name Phone Relationship to Player

Please list any allergies/medical problems, including those requiring maintenance medications. (I.e. Diabetic, Asthma, Seizure Disorder)

Medical Diagnosis	Medication	Dosage	Frequency

The purpose of the above 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: _____

Mr. /Mrs. /Ms. _____

Authorized Parent/ Guardian Signature Date