



MEDICAL RELEASE

As the parent or 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, and staff, duly licensed Doctor 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 the examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above person.

Date of Child's Birth _____ Date of Last Booster _____

Known Allergies of Child (Including Medication) _____

My Child has the following Medical Problem (s), which should be noted _____

Family Physician _____ Phone Number () _____

Next of Kin to Notify _____ Phone Number () _____

Close Friend _____ Phone Number () _____

Person Responsible for Charges _____

Street Address or P.O. Box _____

City _____ State _____ Zip Code _____

Home Phone Number () _____ Work Phone Number () _____

Primary Insurance Carrier _____

Policy Number _____

Secondary Insurance Carrier _____

In witness of our consent and agreement to the medical authorization specified herein, we have subscribed our signatures on this _____ day of _____, in the year _____.

Notary Parent or Guardian