CSA FLORIDA MEDICAL RELEASE FORM

I, _____ (parent/guardian's name) hereby give permission for any and all medical attention to be administered to my child_____ (child's name) in the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

Address: _____
Home Phone: _____
Insurance Co: _____
Policy Number: _____

In case I cannot be reached, any of the following person/s is/are designated to act on my behalf:

Coach: _____
Assistant Coach: _____
Team Manager: _____
Parent: _____

Medical Information

Physician: _____
Address: _____
Phone: _____
Known Allergies: _____

Signature (parent/guardian) _____ **Date** _____

Subscribed and sworn before me,
this _____ day of _____, 201_

_____
Witness