MEDICAL RELEASE FORM

As the parent/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 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 player's birth	month	day	year	**Date of last tetanus booster**	month	day	year

Known allergies of this player, including any allergies to medicine:

Any other medical problems which should be noted:

Family Physician		**Phone**	
Parent/Guardian		**Home Phone**	
		Work/Cell Phone	
Parent/Guardian Address		**City, State Zip**	
Person responsible for charges, if differs		**Home Phone**	
		Work/Cell Phone	
Person responsible for charges address		**City, State Zip**	
Person to notify if parent/guardian unavailable		**Home Phone**	
		Work/Cell Phone	
Insurance Carrier		**Policy Number**	
Policy-holder's Name		**Group Number**	
Carrier's Phone Number			

Signature of parent/guardian _____ **Date** _____