CENTRAL WESTERN AAU
2013 MEDICAL RELEASE FORM

I hereby give permission for any and all medical attention necessary to be administered to my child in the event of an accident, injury, sickness, etc., under the direction of the people listed below until such time as I may be contacted.

My child's name is:

(Print Name)_____

This release is effective for the time during which my child is participating in the Central Western New York Youth Basketball Clubs Inc, practices and any tournaments they will be competing in for the 2013 season, including traveling to and from such tournaments. I also hereby assume responsibility for payment of any such treatment. Furthermore, my child being a member of the Amateur Athletic Union will be entitled to any or all secondary coverage's which come into consideration in this matter.

I also understand that the insurance being provided my child as a member of the Amateur Athletic Union becomes a primary insurance if I have checked the appropriate box on the membership card indicating that I have no health coverage.

Parent or Guardian (print name) -

_____

Signature of Parent or Guardian -

_____

Date_____

Parent/Guardian E-Mail Address -

_____

Parent/Guardian Cell Phone # - (_____) _____

TURN OVER

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As the parent/legal guardian of:

Name of Player:	

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 players birth:		**Date of last Tetanus Booster:**	
Know allergies of this player, including any allergies to medicine:			
Any other medical problems which should be noted:			

Family Physician:		**Phone:**	**( )**

Parent/Guardian:					
Street Address:					
City:		**State:**		**Zip:**	
Phone # H:	**( )**	**Work #:**	**( )**		
Cell Phone #1	**( )**	**Cell Phone #2**	**( )**		

Person responsible for charges: (if different from above)					
Street Address:					
City:		**State:**		**Zip:**	
Phone # H:	**( )**	**Work #:**	**( )**		

Person to notify if Parent/Guardian is NOT available:					
Street Address:					
City:		**State:**		**Zip:**	
Phone # H:	**( )**	**Work #:**	**( )**		

Insurance Carrier:		**Policy Number:**	
Name of Insured:		**Phone:**	**( )**

Print Parent/Guardian Name:_____

Signature of Parent /Guardian:_____

Date:_____ **Witness:** _____

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