



MEDICAL RELEASE

PART 1-PARENT/LEGAL 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: _____

PART 2-IN CASE OF EMERGENCY CONTACT:

Name (Please Print) Phone Relationship to Player

Name (Please Print) Phone Relationship to Player

PART 3-PLEASE LIST ANY ALLERGIES/MEDICAL PROBLEMS, INCLUDING THOSE REQUIRING MAINTENANCE MEDICATION. (I.E. DIABETIC, ASTHMA, SEIZURE DISORDER)

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

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 Toxoid Booster: _____

Mr./Mrs/Ms. _____

Parent/Legal Guardian Signature