

## MEDICAL RELEASE FORM

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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 COMP: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_

I in case I cannot be reached, and of the following persons is designed to act on my behalf.

COACH: \_\_\_\_\_

ASST. COACH: \_\_\_\_\_

MANAGER: \_\_\_\_\_

- \* A league representative where my child is playing.
- \* Any tournament representative where my child is participating in a tournament

PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

KNOWN ALLERGIES: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(PARENT/GUARDIAN)