Medical Release Form

Please Print Clearly

Player _____ Date of Birth _____/_____/_____

Known allergies of player, including allergies to medicine _____

_____

Any other medical conditions which should be noted _____

_____

Name of Parent/Guardian(s)_____

Address _____

City/State/Zip_____

Phone: Home_____ Cell_____ Cell_____

Emergency contact if parent unavailable: _____

Phone: Home_____ Cell_____

Insurance Carrier_____ Group/Policy No._____

Family Physician _____ Phone _____

As the parent or legal guardian of the above-named player, I hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my dependent.

Signature of Parent/Guardian _____

Date _____