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PLAYER MEDICAL RELEASE

As the parent/legal guardian of (insert child's name) _____, 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 any x-ray treatment of the above-named 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.

Any known allergies or medical problems of this player, including allergies to medicines:

Family Physician: _____ Phone: _____
 Insurance Carrier: _____ Policy #: _____

Player's Information:

Address: _____
 Street City State Zip

Home Phone: _____

Email: _____

Name of Parent/Guardian: _____

Phone: _____
 Home Work Cell

Emergency Contact #1 (If parents are not available): _____

Emergency Contact #2 (If parents are not available): _____

Signature of Parent/Guardian: _____

Date: _____

Subscribed and Sworn By Me This _____ Day of _____

Notary Public _____