MEDICAL RELEASE FORM

As the parent/legal guardian of _____, 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 ___/___/_____

Known allergies of the player, including any allergies to medicine._____

_____

Any other medical problems which should be noted. _____

_____

Family Physician _____ Phone (_____)_____

Name of Parent/Guardian _____

Address _____

City/State/Zip _____

Phone _____ H _____ C _____ W _____ FAX

Person responsible for charges (if different from above) _____

Address _____

City/State/Zip _____

Phone _____ H _____ C _____ W _____ FAX

Person to notify if parent/guardian is unavailable _____

Phone _____ H _____ C _____ W _____ FAX

Insurance Carrier _____ Policy Number _____

Signature of Parent/Guardian _____