

MEDICAL RELEASE

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. This is to be done under the direction of the person(s) listed below, until such time as I may be contacted. I also hereby assume the responsibility for payment of any such treatment.

Player Birthdate: _____ Last Tetanus Booster: _____

Known allergies: _____

Unusual Conditions: _____

Our physician is: _____ Phone: _____

Parent / Guardian: _____

My address is: _____

Home Phone: _____ Office Phone: _____

Pager: _____ Cellular: _____

Emergency Contact: _____ Phone: _____

Insurance company: _____ Policy number: _____

This release is effective until such time as revoked by me in writing

In case I cannot be reached, _____ is designated as my legal representative.

Signature: _____

Subscribed and sworn to before me this _____ day of _____, 200 .

Notary: _____