MEDICAL RELEASE FORM

TO WHOM IT MAY CONCERN:

THIS IS TO CERTIFY THAT I/WE THE PARENT(S) OR GUARDIAN(S) OF:

_____

(please print name)

HEREBY STATE, THAT IN CASE OF EMERGENCY, IF THE FAMILY PHYSICIAN CANNOT BE REACHED, THAT I(WE) AUTHORIZE THE ADULT MANAGER, COACH OR LEAGUE OFFICIALS PERMISSION TO OBTAIN MEDICAL CARE AND TREATMENT BY ANOTHER QUALIFIED LICENSED PHYSICIAN, HOSPITAL, EMS OR MEDICAL CLINIC FOR THE PLAYER NAMED ABOVE. THIS AUTHORIZATION SHALL INCLUDE ALL TEAM AND LEAGUE ACTIVITIES, INCLUDING THE PERIOD REQUIRED TO TRAVEL TO AND FROM THOSE ACTIVITIES.

SIGNED_____

RELATIONSHIP_____

SIGNED_____

RELATIONSHIP_____

DATE _____

MEDICAL INSURANCE _____

POLICY # _____

GROUP OR ORGANIZATION _____

TELEPHONE # _____

FAMILY PHYSICIAN _____

TELEPHONE # _____

ALLERGIES _____

ANY MEDICAL PROBLEMS _____