

# MEDICAL RELEASE FORM

I, \_\_\_\_\_ (Parent/Guardian's Name) hereby give permission for any and all medical attention to be administered to my child \_\_\_\_\_ (Child's Name) In the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

ADDRESS: \_\_\_\_\_  
.  
HOME PHONE: \_\_\_\_\_  
INSURANCE COMP: \_\_\_\_\_  
POLICY NUMBER: \_\_\_\_\_

In case I cannot be reached, any of the following persons is designated to act on my behalf.

- \* COACH: \_\_\_\_\_
- \* ASST.COACH: \_\_\_\_\_
- \* MANAGER: \_\_\_\_\_
- \* A league representative where my child is playing.
- \* Any tournament representative where my child is participating in a tournament

PHYSICIAN: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
KNOWN ALLERGIES: \_\_\_\_\_

SIGNATURE (PARENT/GUARDIAN) \_\_\_\_\_ DATE \_\_\_\_\_

Subscribed and sworn before me,  
this \_\_\_\_\_ day of \_\_\_\_\_, 200\_

\_\_\_\_\_  
Notary Public