



MEDICAL RELEASE FORM

treatment. I request Medicine or Doctors diagnostic procedure above minor. I have	be admitted to any hose t and authorize physicial of Dentistry or other su es, treatment procedure e not been given a guar tal or medical facility to	spital or medica ans, dentists, a ch licensed tec s, operative pr antee as to the	al facility for nd staff, duly hnicians or n ocedures and results of ex	 licensed as urses, to per x-ray treatr xamination or 	d Doctors o form any nent of th r treatmer	of ne nt.
Date of Players Birth	// Month Day Year	Date of last 1	Fetanus Boos	ter/ Month D		
Known allergies of th	nis player, including any	allergies to m	edicine			
Any other medical pr	roblems which should b	e noted				
Family Physician		Phone ()			
Name of Parent/Gua	rdian					
Address						
City/State/Zip						_
Phone Home	Cell		Work			
Person responsible fo	or charges (if different f	rom above)				
Address						
City/State/Zip						
Phone Home	Cell		Work			
Person to notify if pa	rent/guardian is unava	ilable				
Phone Home	Cell		Work			
Insurance Carrier Policy Number						
Signature of Parent/	Guardian					