

# MEDICAL RELEASE FORM

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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 payment of any such treatment. This release is effective for a 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: \_\_\_\_\_

\* MANANGER: \_\_\_\_\_

\* A league representative where my child is playing.

\* Any tournament representative where my child is participating in a tournament.

PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

KNOW ALLERGIES: \_\_\_\_\_

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