

MEDICAL RELEASE FORM

PLEASE PRINT ALL INFORMATION EXCEPT SIGNATURE

I hereby give my permission for any and all medical attention necessary to be administered to my child

(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. This release is effective for a period of one year from the date given below. I also assume the responsibility for the payment of any such treatment.

MY ADDRESS IS: _____

HOME
PHONE:(____) _____ OFFICE:(____) _____

MY INSURANCE COMPANY IS: _____

MY POLICY NUMBER IS: _____

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

1. COACH: _____

2. ASST. COACH: _____

3. A league representative where my child is playing

4. Any tournament representative where my child is participating in a Tournament

OUR PHYSICIAN IS: _____

ADDRESS: _____

TELEPHONE: _____

ALLERGIES: _____

SIGNATURE (PARENT OR GUARDIAN): _____

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____, 20____

Notary Public

My Commission Expires: _____