# MEDICAL RELEASE

**NOTE**: To be carried by any Regular Season or Tournament Team Manager

Player: _____ Date of Birth: _____ Gender (M/F):_____
Parent (s)/Guardian Name: _____ Relationship: _____
Parent (s)/Guardian Name: _____ Relationship: _____
Player's Address: _____ City: _____ State/Country: _____ Zip: _____
Home Phone: _____Work Phone: _____ Mobile Phone: _____

**PARENT OR LEGAL GUARDIAN AUTHORIZATION**: Email: _____

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel. (I.e. EMT, First Responder, E.R. Physician)

Family Physician: _____ Phone: _____
Address: _____ City: _____State/Country: _____
Hospital Preference: _____

Parent Insurance Co: _____ Policy No.: _____Group ID#:_____

**If parent(s)/legal guardian cannot be reached in case of emergency, contact:**

_____

Name Phone Relationship to Player

_____

Name Phone Relationship to Player

Please list any allergies/medical problems, including that requiring maintenance medication. (I.e. Diabetic, Asthma, Seizure Disorder)

| Medical Diagnosis | Medication | Dosage | Frequency of Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Date (approximate) of last Tetanus Toxoid Booster: _____

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Mr./Mrs./Ms_____

Authorized Parent/Guardian Signature Date: