

# 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: \_\_\_\_\_  
\_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_

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: \_\_\_\_\_