MEDICAL RELEASE FORM

As the parent/legal guardian of:

Name of Player:	

I request that in my absence the above-named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

Date of players birth:		**Date of last Tetanus Booster:**	
Know allergies of this player, including any allergies to medicine:			
Any other medical problems which should be noted:			

Family Physician:		**Phone #:**	( ) -

Name of Parent/Guardian:							
Street Address:						**City:**	
State:		**Zip Code:**		**Phone # H:**	( ) -	**Work #:**	( ) -

Person responsible for charges (if different from above)							
Street Address:						**City:**	
State:		**Zip Code:**		**Phone # H:**	( ) -	**Work #:**	( ) -

Person to notify id parent/guardian is unavailable:							
Street Address:						**City:**	
State:		**Zip Code:**		**Phone # H:**	( ) -	**Work #:**	( ) -

Insurance Carrier:		**Policy Number:**	

Signature of Parent /Guardian: _____

JURAT

STATE OF _____ §

§

COUNTY OF _____ §

Sworn to and subscribed before me on the _____ day of _____, 200__.

_____

Notary Public in and for the State of _____

Commission expires _____