

# 2016 MEDICAL RELEASE FORM

As the parent/legal guardian of \_\_\_\_\_, 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.

Birth Date of Player \_\_\_\_\_ Date of last Tetanus Booster \_\_\_\_\_

Known allergies of this player, including allergies to medicines \_\_\_\_\_

Any other medical problems that should be noted \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_  
(Please print)

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Person responsible for charges (if different from above) \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Person to notify if parent /guardian is unavailable \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy No. \_\_\_\_\_

Signature of Parent/Guardian X \_\_\_\_\_ Date \_\_\_\_\_