

# 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:

\_\_\_\_\_  
.

HOME PHONE:

\_\_\_\_\_

INSURANCE COMP:

\_\_\_\_\_

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 \_\_\_\_\_

Subscribed and sworn before me,

this \_\_\_\_\_ day of \_\_\_\_\_, 201\_

\_\_\_\_\_  
Notary Public