MEDICAL RELEASE FORM

(Please Print)

I hereby give my permission for any and all medical attention necessary to be administered to my child (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. This release is in effect for one year from the date given below. I also hereby assume the financial responsibility for the payment of such treatment.

Parent(s) full name(s): _____

Home Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone(s): _____

Child's DOB: _____

Name of Employer: _____

Insurance Company Name and Address: _____

_____

Insurance Policy Number: _____

In case I cannot be reached, I hereby designate any of the following person(s) to act on my behalf:

Coach: _____ Phone: _____

Assistant Coach: _____ Phone: _____

Manager: _____ Phone: _____

Our family physician: _____

Physician's Address: _____

Physician's Phone: _____

Known Allergies: _____

Any other medical conditions: _____

_____

Signature of Parent/Guardian: _____ Date: _____

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Subscribed and sworn by me this _____ day of _____, 20_____

Notary Public: _____

My Commission Expires: _____