

MEDICAL RELEASE FORM

I, _____ (Parent/Guardian's Name) hereby give permission for any and all medical attention to be administered to my child _____ 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: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CONTACT #: _____

INSURANCE CO: _____

POLICY # _____

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 _____, 200__

NOTARY PUBLIC