

## **MEDICAL RELEASE FORM**

I, \_\_\_\_\_ (Parent or 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:

\_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

In case I cannot be reached, any of the following persons is designated to act on my behalf:

- Coach \_\_\_\_\_
- Asst.Coach \_\_\_\_\_
- Manager \_\_\_\_\_
- Any tournament representative where my child is playing
- A league Representative where my child is participating in a tournament.

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Known Allergies: \_\_\_\_\_

Signature (Parent or Guardian) \_\_\_\_\_

DATE \_\_\_\_\_

Subscribed and sworn before me \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_

Notary Public