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.

Date of player's birth: _____ / _____ / _____ (MONTH / DAY / YEAR) Date of last tetanus booster: _____ / _____ / _____ (MONTH / DAY / YEAR)

Known allergies of this player, including any allergies to medication: _____

_____

Are there any other medical problems that should be noted: _____

_____

Family physician: _____ Telephone: ( ) _____

Name of parent/guardian: _____

Address: _____

City / State / Zip: _____

Telephone: ( ) _____ (HOME) ( ) _____ (WORK) ( ) _____ (FAX)

Person responsible for charges (if different from above): _____

Address: _____

City / State / Zip: _____

Telephone: ( ) _____ (HOME) ( ) _____ (WORK) ( ) _____ (FAX)

Person to notify if parent/guardian is unavailable: _____

Telephone: ( ) _____ (HOME) ( ) _____ (WORK) ( ) _____ (FAX)

Insurance carrier: _____ Policy number: _____

JURAT

STATE OF _____

COUNTY OF _____

Sworn to and subscribed before me on the _____ day of _____, 20 ____

_____

Notary Public in and for the State of _____

Commission expires _____