

MEDICAL RELEASE



NOTE: To be carried by any Regular Season or Tournament Team Manager together with team roster or International Tournament Affidavit.

Player:	Date of Birth:	Gend	ler (M/F):
Parent(s)/Legal Guardian Nam	ne:	Relationship:_	
Parent(s)/Legal Guardian Nam	ne:	Relationship:_	
Player's Address:	City:	State/Country:_	Zip:
Home Phone:	Work Phone:	Mobile Ph	one:
PARENT OR LEGAL GUAR	DIAN AUTHORIZATION:	Email:	
	physician cannot be reached, I he T, First Responder, E.R. Physician		child to be treated by Certified
Family Physician:		Phone:	
Address:	City:	State/Country:	
Hospital Preference:			
Parent Insurance Co:	Policy No.:	Group ID#:	
League Insurance Co:	Policy No.:	League/Group ID#:	
Name	Phone		Relationship to Player
Name	Phone		Relationship to Player
Please list any allergies/medical p	problems, including those requiring mainter	nance medication (i.e. Di	abetic, Asthma, Seizure Disorder).
Medical Diagnosis	Medication	Dosage	Frequency of Dosage
Date of last Tetanus Toyoid Bo	oster:		
	n is to ensure that medical personnel have deta		which may interfere with or alter treatme
Mr./Mrs./Ms.		ilis of any modical problem	which may intended with or after treatmen
Authorized Pa	arent/Legal Guardian Signature		Date:
FOR LEAGUE USE ONLY:			
League Name:		League ID:	
Division:	Team:	Date:	