

MEDICAL RELEASE FORM

I, _____ (Parent/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:

HOME PHONE:

INSURANCE COMP:

POLICY NUMBER:

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