

## 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: _	Gender (M/F):	
Parent(s)/Legal Guardian N	lame:	_ Relationship:	
Parent(s)/Legal Guardian N	lame:	_ Relationship:	
Player's Address:	City:	_ State/Country:	Zip:
Home Phone:	Work Phone:	Mobile Pho	one:
PARENT OR LEGAL GUA	ARDIAN AUTHORIZATION:	Email:	
In case of emergency, if far Emergency Personnel(i.e. I	nily physician cannot be reached, I her EMT, First Responder, E.R. Physician).	eby authorize my o	child to be treated by Certifie
Family Physician:		Phone:	
Address:	City:	State/Country:	
Hospital Preference:			
		Group ID#:	
League Insurance Co:	Policy No.:	League/Group ID#:	
If Parent(s)/Legal Guardia	in cannot be reached in case of eme	ergency, contact:	
Name	Phone		Relationship to Player
Name	Phone		Relationship to Player
Please list any allergies/medic	cal problems, including those requiring maintena	nce medication (i.e. Dia	betic, Asthma, Seizure Disorder).
Medical Diagnosis	Medication	Dosage	Frequency of Dosage
	I		
Date of last Tetanus Toxoid	Booster:		
The purpose of the above listed inform	nation is to ensure that medical personnel have details	of any medical problem w	hich may interfere with or alter treatme
Mr./Mrs./MsAuthorized	Parent/Legal Guardian Signature		Date:
, (31.57)200			24.6.
FOR LEAGUE USE ONLY:			
_eague Name:		_League ID:	
Division:	Team:		Date: