MEDICAL RELEASE FORM **Age: _____ Boys or Girls**

Please print all information except signature

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:_____

_____

PHONE #:_____

INSURANCE COMP: POLICY #:_____

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

Name:_____Phone #:_____

Name:_____ Phone #:_____

* COACH: *ASST COACH:

* MANAGER(S):

PHYSICIAN:_____ PHONE:_____

KNOWN ALLERGIES OR MEDICAL
CONDITIONS:_____

SIGNATURE (PARENT/GAURDIAN) _____

DATE _____

Subscribed and sworn before me,

This _____ day of _____ , 20 _____

_____

Notary Public