MEDICAL RELEASE FORM

In the event that _____needs medical care during his/her official participation you have my permission to arrange for medical treatment when necessary and performed by a licensed qualified physician. (Parent/guardian named on application will be notified in case of emergency.)

Athletes Name _____

Address _____
Street Apartment No.

_____
(City) (State) (Zip)

Date of Birth: Month _____ Day _____ Year _____

Home Phone No: ( ) _____ Parent/Guardian Work No. ( ) _____

Medical/Health Insurance Company _____

I.D.#, Group/Contract#, Benefit# _____

Does athlete have allergies to medication or other important medical factors? ( ) Yes ( ) No

If yes, please explain _____

_____

_____

Prescribed medication/condition or physical handicap _____

_____

_____

Person other than parent/guardian to be contacted in case of emergency:

Name _____ Phone No. ( )_____

Relationship to Athlete _____

_____ _____
Parent/Guardian Signature Date