## MEDICAL RELEASE FORM

As the parent/legal guardian of	, I request that in my
absence the above-named player be admitted to any hospit	al or medical facility for
diagnosis and treatment. I request and authorize physician	s, dentists, and staff, duly
licensed as Doctors of Medicine or Doctors of Dentistry or	r other such licensed
technicians or nurses, to perform any diagnostic procedure	es, treatment procedures,
operative procedures and x-ray treatment of the above min	or. I have not been given a
guarantee as to the results of examination or treatment. I a	uthorize the hospital or
medical facility to dispose of any specimen or tissue taken	from the above-named player.
Date of Players Birth/ Date of last T	etanus Booster//
Month Day Year	Month Day Year
Known allergies of this player, including any allergies to r	nedicine
Any other medical problems which should be noted	

Family Physician	F	Phone ()
Name of Parent/Guardian	n	
Address		
		FAX ()
Person responsible for ch	arges (if different from abo	ove)
Address		
		FAX ()
	auardian is unavailable	
Person to notify if parent	guaruran is unavailable	
<b>7</b> 1		FAX ()