MEDICAL RELEASE FORM

I hereby give my permission for any and all medical attention necessary to be administered to my child, _____ in the event of an accident, injury, sickness, etc., under the direction of the person[s] listed below, until such time as I may be contacted. This release is effective for a period of one year from the date given below. I also hereby assume the responsibility for payment of any such treatment.

Birth Date: _____ Date of Last Tetanus Booster: _____

Known Allergies (Include Medicine): _____

Known Medical Problems: _____

_____

Insurance Carrier: _____ Policy: _____

Parent/Guardian: _____ Phone: (_____) _____
(home)

Address: _____

_____ (_____) _____
(work)

Person To Notify If Parent/Guardian Is Unavailable:

_____ _____ _____
(name) (home phone) (work phone)

_____ _____ _____
(name) (home phone) (work phone)

Physician: _____

Address: _____

_____

Phone: (_____) _____

In case I cannot be reached, either of the following is my designated representative:

Coach: _____
(phone)

Asst Coach: _____
(phone)

Signature of Parent/ Guardian: _____ Date: _____

Subscribed And Sworn To Me This _____ Day Of _____ , 20___

_____
(notary public)