

MEDICAL RELEASE FORM

treatment. I request and Medicine or Doctors of diagnostic procedures, t above minor. I have not I authorize the hospital	authorize physicians, dentists, Dentistry or other such license reatment procedures, operative been given a guarantee as to the	, I request that in tal or medical facility for diagnosis and and staff, duly licensed as Doctors of the dechnicians or nurses, to perform any a procedures and x-ray treatment of the he results of examination or treatment. If any specimen or tissue taken from the
above-named player.		
Birth Date of Player	_//Date of last Tetar	nus Booster//
Known allergies of this	player, including any allergies	to medicine
Any other medical prob	lems which should be noted	
Family Physician		Phone #
Insurance Carrier		Policy Number
Name of Parent/Guardia	an	
Address		
Home Phone	Work Phone	FAX
Person responsible for c	charges (if different than above)
Address		
		FAX
Home Phone	Work Phone	FAX
Signature of Parent/Gua		