MEDICAL RELEASE FORM

I, _____ (Parent/Guardian's Name) hereby give permission for any and all medical attention to be administered to my child_____(Child'sName), _____(date of birth), in the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time 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:_____
_____
Emergency #s:_____
Email: _____
Insurance Comp:_____
Policy/Group #:_____

In the event I may not be reached, any of the following persons is designated to act on my behalf.
*Coach:_____
*Team Manager:_____

PHYSICIAN:_____
Address:_____
Phone:_____
Known Allergies:_____
Known Medical Condition:_____

_____
Signature (Parent/Guardian) Date