

MEDICAL RELEASE FORM

I, _____ (Parent/Guardian's Name) hereby give permission for

any and all medical attention to be administered to my child

_____.

In the event of accident, injury, sickness, etc., under the direction of the Person(s) listed below, until such time as 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.

HOME ADDRESS:

HOME PHONE:

INSURANCE COMP:

POLICY NUMBER:

In case I cannot be reached, any of the following persons is designated to act on my behalf.

* COACH: _____

* ASST.COACH/TRAINER: _____

* PARENT: _____

* A league representative where my child is playing.

* Any tournament representative where my child is participating in a tournament

PHYSICIAN: _____

ADDRESS: _____

PHONE: _____

KNOWN ALLERGIES: _____

SIGNATURE (PARENT/GUARDIAN) _____ DATE _____

Subscribed and sworn before me,

this _____ day of _____, 200__

Notary Public