Medical Release Form

I hereby give permission for any and all medical attention necessary to be administered to my child (name) _____ in the event of accident, injury, sickness, etc., under the direction of either of the person(s) designated below, until such time as I may be contacted. If neither of the person(s) designated below can be contacted, I give permission for treatment of my child as may be required subsequent to a determination made by the appropriate health care professional who is present. This release is effective until revoked, in writing, by me. I also hereby assume responsibility for payment of such treatment.

My name: _____ Phone (Home):_____

(Work): _____ (Cell): _____

My address: _____

City: _____ State: _____ Zip: _____

My insurance company is: _____

My insurance policy number is: _____

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

Coach: _____ Phone: _____

Assistant coach: _____ Phone: _____

My physician: _____ Phone: _____

Physician's address: _____

Known allergies of child: _____

_____

Signature (parent): _____

Parent's name (print): _____

Date: _____