MEDICAL RELEASE FORM

I, ______________________________ **(Parent/Guardian)** hereby give permission for any and all medical attention to be administered to my child, ______________________________ **(Child's Name)**, 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.

Coach: ______________________________

Asst Coach: ______________________________

Team Manager: ______________________________

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

My Address: ______________________________

City/State/Zip: ______________________________

Relationship: ______________________________

Home Phone: ______________________________

Office Phone: ______________________________

Cell Phone: ______________________________

Insurance Company: ______________________________

Policy Number: ______________________________

Physician: ______________________________

Physician's Phone: ______________________________

Known Allergies: ______________________________

Other Information: ______________________________

Signature of Parent/Guardian: ______________________________

Date: ______________________________