MEDICAL RELEASE FORM

As the parent/legal guardian of		, I request that in my absence the
		lical facility for diagnosis and treatment. I
request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors		
		ses, to perform any diagnostic procedures,
		atment of the above minor. I have not been
		eatment. I authorize the hospital or medical
facility to dispose of any specimen		
racinty to dispose of any specimen	of tissue taken from the	e above-named player.
Data of playang Pinth	Data of last T	otonus Poostor
Month Day	Year Date of fast 10	etanus Booster / / Month Day Year
Month Buy	Tetti	Month Bay 1 car
Known allergies of this player, including any allergies to medicine:		
Tenown unergies of this player, including any unergies to incureine.		
Any other medical problems which should be noted:		
Family Physician		Phone () -
1 441111 1 119 010 10111		
Name of Parent/Guardian		
Address		
erty/state/21p		
Phone (H)	(W)	(F)
Person responsible for charges (If d	ifferent from above)	
Address		
City/State/Zip		
Phone (H)	(W)	(F)
Person to notify if parent/guardian	is unavailable	
Phone (H)	(W)	(F)
Insurance Carrier		Policy #
Signature of Parent/Guardian		