MEDICAL RELEASE FORM

As the parent/ legal guardian of ________________________________, I request that in my absence the above-named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technician or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

Player's Date of Birth _____/_____/_____

Date of Last Tetanus Booster _____/_____/_____

Known allergies, including any allergies to medicine ______________________________

____

Any other medical problems which should be noted ______________________________

____

Family Physician ______________________ Phone (____) ______________

Name of Parent/ Guardian ____

Address ____

Phone C (____) ____________ H (____) ____________ W (____) ____________

Person responsible for charges (if different from above) ______________________

Address ____

Phone C (____) ____________ H (____) ____________ W (____) ____________

If Parent/Guardian unavailable, please contact:

Name ____

Phone C (____) ____________ H (____) ____________ W (____) ____________

Insurance Carrier Name ______________________ Policy Number ______________

____

Printed Name of Parent/ Guardian

______________________________ ______________

Signature of Parent/ Guardian Date

Approved & Adopted by WCOSA League Members: April 20, 2015