



MEDICAL RELEASE FORM

I, _____ (**Parent/Guardian's Name**) 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.

Address: _____

City: _____, **FL Zip Code:** _____

Home Phone: (_____) _____ - _____ **Cell Phone:** _____

Insurance Company: _____

Policy Number: _____ **Physician Name:** _____

Parent's Email Address: _____ @ _____

Physician's Address: _____

Physician's Phone: _____

Known Allergies: _____

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

* **Coach Name:** _____

* **Assistant Coach:** _____

* **Team Manager:** _____

* A league representative where my child is playing.

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

SIGNATURE (PARENT/GUARDIAN) _____ **DATE:** ____/____/____