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 Doctor of Medicine or Doctors of Dentistry or other such licensed technicians 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.

Date of players Birth _________/_____/____
Month Day Year

Known allergies of this player, including any allergies to medicine: _______________________________________

____

Any other medical problems which should be noted: ____

____

Name of Parent/Guardian: ____

Address: ____

City/State/Zip: ____

Phone (H): _________________________________ Phone (ALT): ____________________________________

Person to notify if parent/guardian is unavailable: ____

Phone (H): _________________________________ Phone (ALT): ____________________________________

STATE OF FLORIDA, COUNTY OF ____

The foregoing document was acknowledged before me this _______day of _____________, 20_____, by

____

____
Notary Public Signature

Personally Known______ or Produced Identification________

____ Signature of Parent/Guardian

____ Type of ID Produced and ID Number