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 Director 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 of 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: ______/______/______
Month Day Year Month Day Year

Known Allergies of this player, including any allergies to medications:________________
____
____

Any other medical problems which should be noted:_______________________________
____
____

Family Physician___________________________________Phone (_____)_____________

Name of Parent/Guardian____

Address ____________________________________ City/State/Zip ________________________

Phone (H) ______________________(W) _____________________(Cell) ___________________

Person to notify if parent/guardian is unavailable ____

Phone (H) ______________________(W) _____________________(Cell) ___________________

Insurance Carrier _____________________________ Policy Number ________________________

Signature of Parent/Guardian _______________________________ Date ________

STATE OF FLORIDA
COUNTY OF MANATEE

Subscribed and sworn to before me this __________day of ______, 2020
By ____________________________ who is personally known to me or has provided proper
I.D. # _________________________TYPE _________________________.

____
PUBLIC NOTARY