MEDICAL RELEASE

I hereby give my permission of any and all medical attention necessary to be administered to my child (NAME) _____ in the event of an accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. This release is effective for a period of one (1) year from the date given below.
I also hereby assume the responsibility for payment of any such treatment.

MY ADDRESS IS_____

HOME PHONE: (___) _____ WORK PHONE: (____) _____

MY INSURANCE COMPANY IS_____

MY POLICY NUMBER IS_____

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

1. Coach (Name)_____
2. Assistant Coach (Name)_____
3. Assistant Coach (Name)_____
4. A League Representative where my child is playing
5. Any Tournament representative where my child is participating in a tournament

OUR PHYSICIAN IS_____

PHYSICIAN ADDRESS_____

KNOWN ALLERGIES_____

SIGNATURE (PARENT/GUARDIAN) _____

SUBSCRIBED AND SWORN TO BEFORE ME, THIS _____ DAY OF _____, 20_____

_____

Seal Notary Signature