## **MEDICAL RELEASE FORM**

As the parent/legal guardian of:

Name of Player:

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 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:		]	Date of last Tetanus Booster:								
Allergies:											
Other Medical Conditions:											
Player's Physician:					Phon	e #: _(	)	-			
Name of Parent/Guardian:											
Street Address:										State:	TX
Zip Code:	Phone # H:	(	)	-		Work #:	(	)	-		
Person responsible for char	ges (if different from	above)									
Street Address:				City:						State:	TX
Zip Code:	Phone # H:	(	)	_		Work #:	(	)	-		
Person to notify if parent/g	uardian is unav	ailable:									
Street Address:				City:						State:	
Zip Code:	Phone # H:	(	)	-		Work #:	(	)	-		
						)	-				
Medical and/or Hospi	tal Insurance C	0			Phon	e #:					
Policy Holder				Polic	y Numł	ber					
Signature of Parent /Guardian:			Date:								
Sworn to and subscribed before me on the			_ da	y of		,	Yr				
					y Public _						
		My Commission expires									

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