Team Impact

MEDICAL RELEASE FORM

Player's Name ________________________________ Date of Birth: ____________________________

Father's Name: ________________________________ Mother's Name: __________________________

Player's Address: ____

Home Phone Number(s): ____________________ Work Phone Number(s): ______________________

Cell Phone Number(s): ____

In an emergency when parents cannot be reached, please contact:

Name: _______________________ Cell Phone: ____________________ Work: ___________________

Name: _______________________ Cell Phone: ____________________ Work: ___________________

Player Information:

Allergies: ____

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Asthma (Yes or No): ________________ Blood Type (if known): __________________________

Date of last tetanus booster: _______________ Regular Medications: ___________________________

Additional Information:

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Medical Insurance Carrier: _________________________________ Policy #: ______________________

Insurance Contact Phone #: _________________ Policy Holder Name: ____________________________

Player's Physician: ______________________________ Phone #: ________________________________

CONSENT FOR MEDICAL TREATMENT

I, ______________________________, am the parent or guardian having legal custody of the above player. I authorize all medical, surgical, diagnostic, and hospital care or procedures which may be performed or prescribed for my child by a licensed physician or hospital, when efforts to contact me are unsuccessful and when deemed immediately necessary or advisable by the physician to safeguard my child's health. I waive my right of informed consent to such treatment.

Parent / Guardian Signature: ____________________________________ Date: __________________