

# 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: \_\_\_\_\_

Asthma (Yes or No): \_\_\_\_\_ Blood Type (if known): \_\_\_\_\_

Date of last tetanus booster: \_\_\_\_\_ Regular Medications: \_\_\_\_\_

Additional Information:  
\_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_