MEDICAL RELEASE FORM

I,________________________________ **(Parent/Guardian's Name)** hereby give permission for any and all medical attention to be administered to my child _______________________________ (Child's Name) In the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

Address: ____

City: ____, **FL** **Zip Code**: _____________________

Home Phone: (_________) __________-______________ **Cell Phone:** (_________) __________-______________

Insurance Company: ____

Policy Number: ________________________________ **Physician Name:** _________________________________

Parent's Email Address:_______________________________@_________________________

Physician's Address: ____

Physician's Phone: ____

Known Allergies: ____

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

* **Coach Name:** ____

* **Assistant Coach:** ____

* **Team Manager:** ____

* A league representative where my child is playing.
* Any tournament representative where my child is participating in a tournament

SIGNATURE (PARENT/GUARDIAN) _______________________________________ **DATE:** _______/_______/_______