TCT

Medical Release

Player:____________________________________ Date of Birth:____________ Gender (M/F):________________

Parent(s)/Guardian Name:____________________________________ Relationship:__________________________

Parent(s)/Guardian Name:____________________________________ Relationship:__________________________

Player's Address:__________________________________City:________________State:____________ Zip:______

Home Phone:____________________ Mom's Cell:____________________Dad's Cell:________________________

PARENT OR GUARDIAN AUTHORIZATION:
In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (ie..EMT, First Rsponder, E.R., Physician)

Family Physician:____ Phone:______________________________

Address:_________________________________ City:______________________ State:____________________

Hospital Preference:____

Parent Insurance Co:____________________ Policy No:____________________Group ID#:________________

Add. Insurance Co:_____________________ Policy No:____________________Group ID#:________________

If parent(s)/guardian cannot be reached in case of emergency, contact:

Name:________________________________ Phone:_____________________Relation:___________________

Name:________________________________ Phone:_____________________Relation:___________________

Please list any allergies/medical problems, inclidng those requring maintenance medications (ie..diabetic, Asthma, ADHD, Seizure Disorder)			
Medical Diagnosis	Medication	Dosage	Frquency of Dose

Date of last Tetanus Toxoid Booster:____

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Mr./Mrs./Ms.____ Date:_____________________________
Authorized Signature

WARNING: Protective Equipment cannot prevent all injuries a player might receive while participating in .