



FOLSOM BASEBALL CLUB

Medical Release

I, _____, parent/guardian of _____

do hereby authorize any Folsom Baseball Club coach, manager or parent of a participating player, to seek out and authorize emergency medical treatment for my son/daughter in my absence, when such treatment is determined to be necessary by a licensed professional medical provider.

Parent/Guardian Signature

Date

Medical Coverage/Plan

Policy/Medical Number

Name of Insured

Preferred Medical Facility

Dental Coverage/Plan

Policy/Patient Number

Name of Insured

Preferred Dental Facility

****Current Medical Conditions (Allergies, Asthma, Medications, Contact Lenses, etc.):

