Moon Area Soft League
Medical Release Form

(Note: To be carried by any Regular Season or Tournament Team Manager together with team roster or eligibility affidavit at all practices/games)

Player's Name: ______________________________ Date of Birth: ____/____/____

Parent or Guardian Authorization: *In case of an emergency, if I or the family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, ER Physician).*

Family Physician: ______________________________ Phone: ______________

Address: ______________________________ City: ______________

Hospital Preference: ______________________________

In case of emergency, contact:

____

Name Relationship to Player

____

Phone (Home) Phone (Work) Phone (Cell)

____

Name Relationship to Player

____

Phone (Home) Phone (Work) Phone (Cell)

Please list any allergies/medical problems, including those requiring maintenance medication: (i.e. diabetic, asthma, seizure disorder) Medical Diagnosis, Medication Dosage/Frequency.

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Allergies: ______________________________

Date of last Tetanus Toxoid Booster: ______________________________

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

Mr./Mrs (print) ______________________________ Date: ______________

Authorized Parent/Guardian Signature: ______________________________

Insurance Information:

Policy Holder: ______________________________

Insurance Co: ______________________________ ID#: ______________

Employer: ______________________________ Group/Plan: ______________