WYLIE SPORTS ASSOCIATION BASEBALL & SOFTBALL MEDICAL RELEASE

NOTE: To be carried by any Regular Season or Tournament Team Manager together with a team roster with phone contact information.

PLAYER NAME:		DATE OF BIRTH:	GENDER (M/F):
PARENT(S)/GUARDIAN NAME:		RELATIONSHIP:	
PARENT(S)/GUARDIAN NAME:		RELATIONSHIP:	
PLAYERS ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE:	WORK PHONE:	MOBILE PHONE:	ALTERNATE:

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. (I.e. EMT, First Responder, E.R. Physician)

FAMILY PHYSICIAN:		PHONE:
ADDRESS:	CITY:	STATE:
HOSPITAL PREFERENCE:		
PARENT INSURANCE COMP.:	POLICY #:	GROUP ID#:
LEAGUE INSURANCE COMP.:	POLICY #:	GROUP ID#:

If Parent(s)/Guardian cannot be reached in case of emergency, contact:		
NAME:	PHONE:	RELATIONSHIP:
NAME:	PHONE:	RELATIONSHIP:

Please list any allergies/medical problems, including those requiring maintenance medications (i.e. Diabetic, Asthma, and Seizure Disorder)

MEDICAL DIAGNOSIS:	MEDICATION:	DOSAGE:	FREQUENCY OF DOSAGE:

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 Parent/Guardian Signature

FOR LEAGUE USE ONLY;		
LEAGUE NAME:		
DIVISION:	TEAM:	DATE: